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ABSTRACT

The foreword states that this publication aims to assist the reader to better understand the dimensions of the drug and alcohol abuse problems of adolescents and the responses of choice by professionals and by those caring for adolescents. These topics are discussed: (1) the stepping stone theory; (2) correlates of substance abuse; (3) identification, assessment, and treatment of adolescent substance abuse; (4) intervention strategies for adolescents with substance abuse problems; (5) treatment programs for alcohol and substance abuse problems; (6) role of school in adolescent substance abuse; (7) the Impact program; (8) drugs and sports; (9) colleges and universities; (10) adolescent substance abuse prevention; and (11) the disease concept of alcoholism. Appendices address the topics of crack cocaine and specific drugs and their effects, and provide a university alcohol and drug questionnaire, a student referral form, and a discussion of how to develop a drug policy. Telephone numbers and/or addresses are given for resources in the areas of Impact Training; drug abuse information; parent programs and activities; student groups; assessing drug abuse problems; training programs; training materials and workshops; school policies; and additional organizations. References to selected Educational Resource Information Center (ERIC) documents are included with their annotations. (ABL)

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Alcohol, Drugs and Adolescents

LAURIE L. LACHANCE

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First Edition, 1989

Alcohol, Drugs and Adolescents

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FOREWORD

Few social issues have so occupied center stage in contemporary USA than the alcohol and drug abuse problems of adolescents. No respecter of social or economic level or geographic region, all adolescents are at risk of the psychological and physical ravages of substance abuse. The difficulty of separating fact from fantasy and distinguishing appropriate from inappropriate interventions has contributed to feelings of frustration and futility by many would-be helpers.

Written by a knowledgeable and insightful researcher, this publication aims to assist the reader to better understand the dimensions of the problem and the responses of choice by professional helpers and involved and caring others. The basic premise adopted by the author, Laurie Lachance, is that effective identification and assessment of substance abuse is a crucial early step in both treatment and prevention programs. Unlike some authors who operate on a rarified theoretical level, Lachance has written with those persons in mind who will use the information to intervene and bring about change. Throughout the publication she has provided examples of operational programs and suggested possible courses of action. Of particular utility is the breadth and depth of resources provided. In five appendices, a reference and resource section, and a selective bibliography of ERIC resources, the author provides a wealth of useful resources. The professionals seeking more information than that provided in the publication need not look further to locate the desired resource.

We hope that you will find this volume both immediately helpful and a reference source useful for some time to come.

Garry R. Walz
Director

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INTRODUCTION

The swimmer from the United States sauntered to the racing block for the start of the prelims at the Olympic Games. He stood as if in a daze. The judges called him a second time. Eventually he took up his position. When the starter said, "Take your mark," he jumped into the water and swam half the length of the pool before realizing he was alone in the water.

The swimmer returned to his block. When the starting gun fired, he remained on the blocks and then entered the water well behind the others. A former world record holder, he ended up coming in fourth—no medals, no record, nothing. He tested positive for drug use and was sent home from the Olympics in disgrace. A year later he was in jail for drug-related offenses. (Leatt, 1987)

The United States is estimated to have the highest levels of illicit drug involvement to be found in any developed country in the world (Johnston, O'Malley, & Bachman, 1985). One of the most tragic aspects of the problem is the degree to which parents, teachers and others cannot recognize the symptoms of drug use.

One of the most tragic aspects of the problem is the degree to which parents, teachers and others cannot recognize the symptoms of drug use.

Research shows that drug use among children is ten times more prevalent than parents suspect (U.S. Department of Education, 1986). A severe problem exists within schools. The percentage of students using drugs by the sixth grade has tripled over the last decade. Now one in six 13-year-olds has used marijuana. Nearly two-thirds of all American young people try an illicit drug before they finish high school (Blau, Gillespie, Felner, & Evans, 1988; Collaboletta, Bratter, & Fossbender, 1983; Collins, 1983; Johnston et al., 1985; Leatt, 1987).

An investigation by Jessor, Donovan, & Widmer (1980) indicated that by the seventh grade, five percent of both females and males were already problem drinkers. This proportion increased steadily in each grade until by grade twelve, it was established that almost 20.6 percent of females, and 40 percent of males had problems with alcohol consumption. In addition to this, the age of beginning drinking is lowered each year. Recent figures place the beginning age for drinking alcohol in the United states at 12.5 years (Horton, 1985; McCurdy, 1986).

A survey reported by the National Institute on Alcohol Abuse and Alcoholism (Department of Health and Human Services, 1982) of men aged 21 to 59 found the highest proportion of

drinking problems among the group aged 21 to 24. These studies suggest that alcohol problems begin early among the youth in the United States, increase continuously in each school year, and peak during students' collegiate and post-graduate years.

Added to the prevalence data are changes in the drugs themselves. Johnston and his fellow researchers have cautioned against the use of prevalence information alone when trying to gain an understanding of the trends in drug use (Johnston et al., 1985). Other dramatic trends are significant. Although prevalence of use of some drugs may be down, the *intensity* of use may be going up (McCurdy, 1986). Today's drugs are more potent and addictive than ever. For example, marijuana today is five to twenty times stronger than it was previously. Crack, a new, highly addictive form of cocaine which is smoked (a particularly dangerous and psychologically addictive method of use—see Appendix A) and the so-called new "designer drugs" (analogs of certain illegal drugs—see Appendix B) have been known to cause permanent brain damage. Slight increases are also being seen in the use of inhalants and PCP (Phencyclidine). In fact, daily use of inhalants, PCP and cocaine have become more prevalent than ever (Johnston et al., 1985; McCurdy, 1986).

Although prevalence of use of some drugs may be down, the intensity of use may be going up. Today's drugs are more potent and addictive than ever.

Social pressures from peer, family and societal role models are at the top of the list of reasons why adolescents take drugs. Predisposition toward rebelliousness, nonconformity, and independence also figure prominently (Towers, 1987).

Some experimentation with mind-altering substances appears to be a part of the adolescent "rites of initiation" (Bratter, 1984). During the 1950s, any drug was considered to be pathological. Thirty years later, in contrast, abstinence from drugs can be defined as "deviant" (Collabolletta et al., 1983).

There is no way to identify with any certainty those who are likely to become alcoholic and those who can drink without problems. What is certain is that those who begin to drink alcohol at a young age are more likely to become involved in a variety of alcohol-related problems, including alcoholism.

Alcohol consumption at the high school level is often regarded as a rite of passage, an integral part of adolescent development (Jessor & Jessor, 1975). Thus, it is normal to experiment with alcohol, and interventions with the vast majority of teens must take this into account in order to be successful (Silverman, 1987).

STEPPING STONE THEORY

The young man told of his experience with drugs and alcohol beginning at age 10. He identified his use of illegal substances as moderate by the time he reached the age of 12. At that time he was smoking approximately one ounce of marijuana per day (the equivalent of a sandwich bag 1/3 filled with the substance), drinking approximately six cans of beer per day, and experimenting with hallucinogens (e.g., L.S.D.) on a weekly basis. (Green & Green, 1985)

There has been debate about the sequential use of drugs. It is likely that the use of a particular drug makes the use of the next most risky or deviant drug in the sequence seem a smaller and more acceptable step. By whatever process, the use of a drug, in and of itself, makes the use of the next in the sequence much more likely. The general policy implication of this conclusion is that if a particular individual is stopped at one point in the sequence he/she will go no farther. The progressively greater legal tolerance for marijuana, although it may be seen as desirable for reasons of political philosophy, is not a favorable development from the point of view of public health. While all marijuana users do not go on to use harder drugs, they are, nonetheless, the population **at risk** for harder drug use (Carlson & Davis, 1988; Rojek, 1988). When the use of marijuana expands, the population at risk increases.

A great deal of emphasis on the stepping stone theory has centered around marijuana use. It is important to note that alcohol precedes marijuana in the developmental sequence and that alcohol serves as the gateway to other drug use. Stated simply, alcohol use precedes *all* other drug use.

It is important to note that alcohol precedes marijuana in the developmental sequence and that alcohol serves as the gateway to other drug use.

Data strongly support the notion that the sequence starts with a legal drug such as tobacco or liquor rather than with marijuana (Lohrmann & Fors, 1986).

Kandel and Yamaguchi (1985) also contend that drug use progresses from use of at least one legal drug, alcohol and/or tobacco, to marijuana and, finally, to other illicit drugs and/or prescribed medications. This is the most likely pattern of progression. Studies conducted by Fors and Rojek supported both problem behavior and progression of drug use theories, but these researchers cautioned that because adolescents engage in one type of drug use behavior does not mean they will indiscriminately engage in all others (Fors & Rojek, 1983).

Use of any particular drug does not, of necessity, lead to the use of other drugs further along in the sequence. In fact, only a small percentage of high school students go on from marijuana to hard drug use. The data merely suggest a similar hierarchical pattern of initiation to drug use. Most likely a logical progression of availability, acceptability, magnitude of effect, and price underlies the sequence. For example, the use of hard drugs rarely takes place in the absence of experimentation with marijuana.

Awareness that the sequence of drug use begins with legal substances emphasizes the need to encompass the whole phenomenon of drug use, both legal and illegal, in any drug program (Mills & Noyes, 1984).

Adolescent Behavior and Substance Abuse

In their research, Jessor & Jessor (1975) found that engaging in problem behavior is not abnormal and provides a number of benefits for adolescents, one of which is that it allows them to claim status as an adult. These behaviors are ones in which adults can engage without penalty and which are actively promoted among adults through advertising and the media. Because they are forbidden to adolescents, if adolescents wish to pretend to adulthood they engage in these behaviors.

Society and Adolescent Substance Abuse

It must be remembered that adolescents do not produce and market alcohol and tobacco. They do not develop advertising campaigns which use former athletes, good times, promises of success and sex to sell products. Adults do these things, in many cases aiming product marketing at adolescents. Adults then wonder why adolescents use and abuse drugs and blame them for so doing.

The Family and Adolescent Substance Abuse

Jessor's research found that children are more likely to engage in problem behavior if their parents engage in such behavior (Jessor & Jessor, 1975). Other studies have found a high correlation between parental drug use and abuse and drug abuse patterns among their children (Blum et al., 1972; Bry, 1982; Hawkins, 1985; Kandel & Vanaguchi, 1985; and Votrin & Wills, 1985). This should not be surprising since parents are major role models for children and the major transmittors of values, attitudes and beliefs. Even more conclusive, however, is the research that revealed a high correlation between parent alcoholism/addiction and alcoholism/addiction in their children. Califano (1982) estimated that there are more than two million children under age twenty with at least one alcoholic parent and identified those children as a high risk group. Seixas (1982) reported that up to 80 percent of children of alcoholics "will not only begin to drink but will drink with little control."

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Though not necessarily correlated with being a member of an alcoholic family, several other factors have been implicated in increasing the risk for drug abuse. On a personal level, they include a personality pattern of aggressiveness coupled with shyness during the early elementary years and precocious, rebellious behavior in adolescence (Hawkins, Zishner, & Catalano, 1985). Family characteristics, beside parental substance use, include overinvolvement by one parent and indifference or permissiveness by the other, and poor family communication patterns and cohesiveness (Lohrmann & Fors, 1986).

IDENTIFICATION OF ADOLESCENT SUBSTANCE ABUSE

A guidance counselor identified an 18-year-old high school senior as possibly having an alcohol problem after hearing about concerns from the basketball coach that the senior had been drinking during the school day. While talking with the counselor, it was determined that the young man had frequently needed places to sleep other than home, because of family disputes, and that his father had died as a result of alcoholism.

Friends of the teen (who was the captain of the varsity basketball team) were concerned because, although he was well-liked and had achieved academic honors, his social life consisted of heavy drinking and they were aware that he had had more than one instance of blacking out (alcohol amnesia). (Newton Youth Drug/Alcohol Program, 1986)

Identifying the adolescent alcohol abuser is difficult but not impossible. While there is no one alcoholic personality, there are tangible and concrete symptoms of which the teacher, administrator and parent can become aware. Early recognition can result in early intervention and treatment. And treatment is essential because frequent and heavy use of any drug among adolescents is often a coping mechanism for dealing with personal problems that need to be confronted and resolved if normal development is to occur. When drugs are used to cover feelings and to cope with stress, normal adolescent social and psychological growth is blocked (Horton, 1985).

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Much of the documentation for identification of variables which influence the initiation of adolescent drug use is taken from the problem behavior research conducted by Jessor & Jessor (1977). Variables contributing to problem behaviors such as substance abuse are:

- personality variables such as high value for independence, low value and low expectation for school achievement and low value for religion;
- environmental variables such as low parental support and control, low peer control, higher value for peer expectations than parental expectations, low parental disapproval of and high peer approval for participation in problem behaviors; and

- proneness variables such as participation in other problem behaviors and low participation in conventional behaviors.

Other researchers have expanded on these variables (Lohrmann & Fors, 1986):

- Family issues, such as lack of closeness with parents and parental drug use;
- Peer influences;
- Depression;
- Portrayal of drug use in popular media and by popular role models;
- High anxiety;
- Low achievement motivation;
- Disregard for rules;
- Deficient social skills and communication skills.

In addition, general characteristics of adolescence such as experimentation with new behaviors and lifestyles, cognitive development, egocentrism and feelings of invulnerability leading to risk-taking behavior should be taken into consideration. These, too, may make adolescents prone to drug experimentation, if not drug abuse, according to Botvin and Wills (1985).

There is some reason to believe that poor grades may have some causal influence on drug usage rather than vice versa as is so often assumed. It may be the case that poor grades lower one's self-esteem and limit one's career options, factors that could lead to an "escape" into drug use (Mills & Noyes, 1984).

Correlates may be very useful as a "case-finding" mechanism. Realizing that those with low grades and/or family histories of substance abuse are at high risk for drug involvement may have an impact on a target group for early prevention.

Some of the common problems arising in the assessment of adolescent substance abuse include:

- differentiating problematic alcohol/drug use from normal adolescent experimentation;
- differentiating abuse of alcohol/drugs from dependency;
- differentiating alcohol/drug problems from general behavior problems, juvenile delinquency, or concomitant mental disorders; and
- expanding standardized assessment tools to measure drug use other than alcohol, as adolescents are more likely to have drug problems than are adults (Pandina, White, & Yorke, 1981).

Beyond these practical problems, debate also arises over the basic concept of adolescent alcoholism or chemical dependency, with some maintaining the view that adolescents have not had the prerequisite time and experience to develop a chronic pattern of dependency (Owen & Nyberg, 1983).

Specific behaviors and characteristics to watch for to determine whether or not alcohol or other drug abuse is occurring include, but are not limited to, the following:

Frequent absenteeism. Alcohol and drug abusers often have poor attendance records at school and work after the onset of heavy usage. Being reported as absent but seen walking around the school building is another concern.

Alcohol and drug abuse is closely correlated with a decline in grades, interest in school work, and school in general. Grades that deteriorate from A's to B's and C's can be just as indicative of problems as failing grades.

Decline in academic performance. Alcohol and drug abuse is closely correlated with a decline in grades, interest in school work, and school in general. Grades that deteriorate from A's to B's and C's can be just as indicative of problems as failing grades. Failing to complete assignments is another behavior pattern associated with drug use.

Lack of interest in extracurricular activities. For the substance abuser, drinking and taking drugs become the number one pursuit. These behaviors are the students' extracurricular activities. The next party, the next drink or opportunity to take drugs, takes on far more significance than sports, working on the school newspaper, or participating in music, drama or student government.

Conflicts with authority figures. Arguments and disagreements with teachers, counselors, coaches, parents, employers, and other authority figures may be a symptom of alcohol or drug abuse if the occurrence is frequent. Some adolescent rebellion is

normal and healthy, but the budding alcoholic will often exceed the normal limits.

Problems with peers. Frequent fights or arguments with peers, including former friends, may suggest a problem. As adolescents become more addicted to alcohol and other drugs, they become less tolerant of others and more likely to find fault, often in loud and aggressive ways.

New peer relationships. When an adolescent suddenly drops a customary group of friends and begins to associate with a new group, increased alcohol and drug usage may be a part of the picture. Alcohol is a very powerful bond in the drug culture of adolescents. And those who abuse alcohol are likely to abuse other drugs.

Evidence of self-destructive behavior. The most serious self-destructive behavior is suicide or suicide attempts. It is believed that more that 40 percent of all suicides and suicide attempts by adolescents are related to alcohol or other drugs (Horton, 1985). Suicide is the third leading cause of death among teenagers in the United States. Other self-destructive behavior associated with substance abuse includes self-inflicted pain such as cigarette burns on the body, initials or symbols carved into the skin and other forms of self-mutilation. Often unexplained cuts and bruises are the results of falls or other accidents during alcoholic blackouts. All of these behaviors are symptoms of serious problems that call for intervention and treatment.

Avoidance and distancing. Teenage substance abusers tend to withdraw from parents, teachers, siblings, and their former friends. This distancing can be physical as well as psychological. Often they prefer to be alone. They don't wish to interact with anyone who may question their behavior or cause *them* to question it. There is often distorted and diminished verbal communication.

Depression. While many adolescents as well as many adults have periods of free-floating depression, drug-abusing adolescents demonstrate this trait more frequently and for longer periods of time. They lose interest in their environment and in other people. They tend to feel inadequate, inferior, worthless and anxious. They may drink to cope with these feelings of depression, but because alcohol is a depressant they become even more depressed. They fall into a dangerous downward cycle which requires prompt and knowledgeable intervention by concerned adults.

Lack of energy. It is normal for adolescents to exhibit great variation in their energy levels. Often it is a matter of getting enough rest and the right amount of exercise, and good nutrition. Normal adolescents recover quickly with renewed surges of energy. The substance-abusing adolescent often lacks energy and doesn't have the resources to bounce back. The alcohol, drugs, and associated lifestyle interrupts healthy sleep patterns, interferes with regular exercise, and leads to the avoidance of nutritious meals. This is another dangerous cycle that can be broken by aware and caring educators.

Impulsive behavior. As adolescents become increasingly addicted to alcohol and drugs they exhibit fewer internal controls. They behave in irrational and self-destructive ways. Anger and rage on the part of males and promiscuity on the part of females are often evidence of alcohol and other drug abuse. Because of the personality disorganization brought on by alcohol consumption, the abuser is often in a confused condition and unable to cope with normal expectations.

Lack of concern about personal well-being and hygiene. The adolescent who comes to class in a disheveled condition with obvious lack of regard for grooming and cleanliness may be an abuser. The teenager who wears no coat or jacket on cold days or no protection from rain may be demonstrating evidence of substance abuse.

Obvious signs of intoxication. Slurred speech, staggering, and alcohol on the breath are obvious signs of intoxication. The adult who ignores these signs is doing the adolescent no favor. The sooner faced the better. While a confrontation with the student and parents may not be pleasant, the consequences of neglecting this behavior can be much more serious.

Evidence of a troubled home life. Children of alcoholic parents have more than a 50 percent chance of becoming alcoholic. This seems to be a matter of heredity as well as environment, as demonstrated by studies of fraternal twins of alcoholic fathers, some of whom were raised apart, and some together. In many cases the twins became alcoholic regardless of the environment. An alcoholic or otherwise troubled home life is likely to nurture alcoholic behavior if there is a predisposition to alcoholism.

Other indicators include poor coordination, wearing dark glasses all of the time, sleeping in class, involvement with illegal activities, problems with the police, possession of drugs or drug

The alcohol, drugs, and associated lifestyle interrupts healthy sleep patterns, interferes with regular exercise, and leads to the avoidance of nutritious meals. This is another dangerous cycle that can be broken by aware and caring educators.

paraphernalia such as pipes, rolling papers, and small decongestant bottles, and use of incense or other "cover-up" scents.

Those who have substance abuse problems are usually the last ones to realize or admit it. They think they can handle it and feel they are still in control. The process of falling into abuse and addiction is very subtle and the stages of addiction incremental. For this reason identification is not always straightforward. The mechanism of denial can also be at work on the part of parents and other adults.

The process of identification is often an overlooked step in many school programs. This step is the link between prevention and treatment; its importance cannot be overemphasized. If the identification process were more successful, the cycle could be halted that much sooner for many adolescents. Considering the progressive nature of the problem, and the diminishing hope for recovery as addiction progresses, interventions that can possibly prevent further damage are worth the effort.

Within the school, determining the extent and nature of the substance abuse problem is the first, and perhaps most crucial, step to be taken. Accurate identification of the problem increases the likelihood that selected strategies will ameliorate the problem. Complete assessment of substance abuse increases the efficiency of planning and helps to assure that the proposed measures are, in fact, appropriate responses.

INTERVENTION STRATEGIES FOR ADOLESCENTS WITH SUBSTANCE ABUSE PROBLEMS

One of the first considerations for intervention is the emotional reaction of the person who suspects the drug problem. A parent or teacher is bound to feel anger, resentment, and possibly guilt. These individual reactions may cause the person to deny or question the evidence and postpone confrontation or referral.

Intervention is an essential aspect of school drug programs and consists of efforts to help students who abuse drugs or are considered at risk of becoming abusers. This component may be missing from many older programs that concentrate on punitive measures to discourage drug use.

Intervention programs usually include both referral and counseling components, but they are a supplement to and not a substitute for prevention programs. The extent of the program is really dependent on the level of abuse, the school staff's expertise, and community resources.

All teachers, administrators and other staff have roles in an intervention program, and those roles should be delineated. Teachers often are first to be exposed to behavior of abusers and need to be trained in how to recognize it, how to counsel students, and when and where to refer them for help.

Teachers often are first to be exposed to behavior of abusers and need to be trained in how to recognize it, how to counsel students, and when and where to refer them for help.

Those in a position to recognize early signs of substance abuse should learn about the extent of the drug problem in their community and be able to recognize the signs of drug use. They should then devise a plan of action. Confrontations should be handled in a calm, objective manner. It is not of much use to confront an adolescent while under the influence of drugs. Parents should seek advice and assistance from drug treatment professionals, or established referral systems who are equipped to provide an assessment. (For more detailed information on school-based intervention, please refer to the sections on School Role and the Impact Program.)

Treatment usually begins with assessment. The assessment process usually determines not only whether an adolescent has a problem with alcohol and/or drugs but hopefully which type of treatment is best suited to the individual's needs. Ideally, the school should have a relationship with several assessment agencies, and be able to recommend or refer the adolescent directly.

Once adolescents have become dependent on drugs or alcohol, freeing them from this dependence can be extremely difficult. Abusers often do not want to surrender the effects of drug use for what they may regard as a harsh reality. Most will resist treatment. Some may pretend to cooperate with the treatment staff, only to return to drug use after release from the program.

Ideally, the school should have a relationship with several assessment agencies, and be able to recommend or refer the adolescent directly.

Types of Treatment

Professional Programs

The most prevalent forms of treatment are (1) drug-free, (2) detoxification, and (3) maintenance. The drug-free mode treats drug use without medication. Its primary method is counseling. Detoxification refers to a treatment of withdrawal from drugs, sometimes with the support of prescribed medication for a limited period with the aim of attracting the abuser into longer-term treatment. If methadone or some other drug substitute is prescribed for longer periods, the treatment mode is called maintenance. The goal of such programs usually is to eliminate criminal behavior among long-term addicts while establishing a more productive lifestyle.

These basic forms of treatment may be provided in a variety of settings: outpatient or residential; at a hospital or in the community; at a public, nonprofit setting or in a private clinic or office. Certain programs are exclusively for adults while some serve adults and youth. Relatively few serve only young people. Other programs specialize in treating only alcohol abusers or only cocaine or heroin abusers. A few treatment facilities specialize in crisis-oriented emergency services for overdoses and "bad trips."

Drug-free residential programs. A residential, drug-free program is sometimes referred to as a "therapeutic community." This kind of program emphasizes facing problems, changing self-destructive behavior, and pursuing constructive alternatives to drug use. It uses group therapy, peer confrontation, and counseling to change the values and behaviors that contributed to the

drug abuse. Such programs may last from two to eighteen months. These programs have the advantage of sheltering the individual from the pressures of the outside world and from drugs, and providing a place where the addict can learn to lead a new drug-free life.

The goal of residential programs is to resocialize the drug abuser by creating a structured, isolated, mutual help environment in which the individual can develop and learn to function as a mature participant.

The goal of residential programs is to resocialize the drug abuser by creating a structured, isolated, mutual help environment in which the individual can develop and learn to function as a mature participant (Einstein, 1981).

The original Therapeutic Community approach sharply restricted the personal freedom of people undergoing treatment and emphasized public criticism, with severe sanctions for violations of the community rules and norms. Now therapeutic communities are replacing confrontational criticism with more supportive strategies. Many present-day residential programs report large populations of polydrug users.

Drug-free outpatient programs. Outpatient drug-free programs at hospitals or clinics may feature such strategies as rap sessions, recreational activities, and personal counseling. The average duration of treatment in a day program is often less than six months.

Over 50 percent of all treatment is in this category, as is most of the treatment for nonopiate drug abusers (Kleber & Slobetz, 1979). It appears that treatment for opiate-abusing clients is becoming separate from that for nonopiate-abusing clients (Sells, 1981).

Drug-free outpatient treatment is the most likely type for young abusers and those entering treatment for the first time. Regardless of type, however, about half of all persons in treatment discontinue it prematurely, either by dropping out or by being dismissed by the facility for rule violation (Kleber & Slobetz, 1979).

Detoxification programs. Detoxification is a medical treatment intended to terminate current drug use through a safe withdrawal procedure. It involves heavily supervised abstinence from the substance as well as medical and psychological support, and usually does not address psychosocial issues (Polich, Ellickson, Reuter, & Kahan, 1984).

Although detoxification followed by outpatient aftercare was once the dominant treatment modality for drug abuse (Polich et al., 1984), its efficacy has been questioned over time.

Detoxification, however, seems appropriate as a preliminary step in the treatment process (Lipton & Maranda, 1982).

Methadone maintenance programs. Methadone Maintenance is the name given to Methadone and other substance substitution treatments. It is a treatment in which a synthetic opiate is administered to the individual as a substitute for the opiate of abuse, typically heroin. Although the individual remains dependent on the substitute, there are several clear advantages to the change of opiate. The synthetic does not produce the same sensations as the original drug of abuse (i.e., the "high"). The synthetic blocks effects of any other opiates, is administered orally rather than by injection, and is longer-acting than other opiates.

The original methadone maintenance model offered chronic maintenance, with little or no psychosocial intervention. A second model, now more popular than the first, offers both psychosocial interventions and plans to taper off and withdraw all drug maintenance (Polich et al., 1984).

Adolescents should not be randomly directed toward various treatment programs; rather, they should be referred based on careful assessment and analysis of their underlying problems.

Self-Help Groups

Unlike the more formal treatment programs, most self-help groups are free of charge. The best known and most successful of these groups is Alcoholics Anonymous (AA), a voluntary, worldwide organization that holds regular meetings for alcoholics of all ages, and whose members strive to help each other attain and maintain sobriety.

In many cases AA groups accept members with drug dependencies other than alcohol and offshoots of the organization using the same basic approach are now in existence. Two examples are Narcotics Anonymous (NA) and Cocaine Anonymous. The companion organizations for the abusers' family members are Al-Anon, and Nar-Anon; the group for teen family members of alcoholics is called Alateen.

Research studies have shown that each of these treatment programs can produce substantial improvement in the social functioning and employment of clients and decreases in drug use and criminality (Polich et al., 1984). Treatment research studies, however, usually do not attempt to evaluate cure rates. Instead,

because drug dependency can be viewed as chronic, few persons are cured to the extent that they are no longer at risk for future problems. They tend to follow a cycle of relapse and treatment that can continue throughout their lives. Because of this it is easy to see how devastating it can be to wait until this stage before taking action.

Completion of a treatment program does not ensure freedom from drug abuse for the rest of one's life; nor is it a solution to all of life's problems. Some adolescents and their families try many programs before they are able to conquer their drug dependence and achieve some stability in their lives. . . .

Completion of a treatment program does not ensure freedom from drug abuse for the rest of one's life; nor is it a solution to all of life's problems. Some adolescents and their families try many programs before they are able to conquer their drug dependence and achieve some stability in their lives and in their relationships with each other. In certain cases they are never able to rise above the drug dependency.

Aftercare

In those cases where treatment seems effective, there is much to be done to remain drug free and to achieve dominance over the underlying problems that caused or exacerbated the drug abuse. Some experts believe recovering drug abusers will carry a predisposition for drug dependence with them for the rest of their lives; therefore they must continue to be guarded and remain abstinent. There is a saying in AA that a recovering alcoholic is just one drink away from the next drunk. In any event, most recovering abusers must continue to work on developing their coping skills, their relationships with other family members, and their ability to make new "straight" friends.

Therefore, continued therapy and continued attendance at AA or NA meetings are recommended (long after the person has completed a formal treatment program). Parents and other family members are also encouraged to continue in parent support groups or to attend Al-Anon meetings. Reintegrating a recovering drug abuser into school also requires special attention that unfortunately is not always provided.

The basic components of a school-based aftercare program should include the following:

- Behavior monitoring involving a system of daily or weekly feedback on the student's behavior and academic work;
- Support groups that offer the student an opportunity to meet with other students with similar backgrounds for understanding and encouragement;

- Goals for recovery that may involve school performance and/or attendance, relationships, and sobriety, and that may be monitored while at the same time giving the student a sense of progress and achievement;
- A case manager assigned to assist the student during the reentry process and to coordinate the school's interaction with the treatment center and other parties during the transition period.

Reentry

Returning from a long-term residential program to home and school is a particularly difficult transition for a young person. When half-way houses are available, they may help students make the adjustment from treatment center to home. Typically, however, the adolescent goes directly back to school—with fear and hope. For many students it is a return to a social situation in which old friends and old expectations create a high-risk situation. At this time, the person is particularly vulnerable and in need of encouragement, support, and understanding if the attitudes and skills learned in treatment are to be maintained.

On occasion, when the student has left school under very negative circumstances, it is worth considering enrollment in a different school. This change protects the student, enabling him or her to start again in a new location without the pressure of old drug-using cronies or a bad reputation among students and faculty.

THE ROLE OF THE SCHOOL IN ADOLESCENT SUBSTANCE ABUSE

The concept of drug/alcohol intervention operated through the public schools is one questioned by many school administrators (Green, 1987). Some argue that schools are for education, not medical or mental health treatment, that the school does not have the responsibility for students' emotional and physical problems. However, when school is the only constant in an adolescent's life, and when children of all ages bring their problems (e.g., drug and alcohol) to the school environment and to the athletic field, the school has the obligation to address these problems and try to implement change.

Some argue that schools are for education, not medical or mental health treatment, that the school does not have the responsibility for students' emotional and physical problems.

It is not realistic (and it is probably dangerous) to expect the schools to be responsible for the problem of substance abuse in adolescents as well as for its solution. Without substantial reinforcement of its goals from the greater society, it is difficult to imagine any school-based program being highly successful. It is easy for parents, politicians and other community members to unload the problem on schools. Schools provide a great *setting* for programs, but cannot do it alone.

What Works—Schools without Drugs, a 1986 publication of the U.S. Department of Education, emphasizes that "although the problems of drug use extend far beyond the schools, it is critical that our offensive on drugs centers on the schools." Educational programs focusing on awareness and prevention make a vital contribution to the ongoing fight against substance abuse.

Specific steps for attacking the drug problem and identifying the roles staff members should play are best laid out in comprehensive school policies and regulations. This removes the uncertainty from the situation and allows each individual to know what role he/she may properly play and which procedure to employ. Questions such as who should call the parent or whether to hold a student's confession in confidence are then answered clearly.

Training staff, assessing the scope of the problem, enforcing rules, and forming coalitions with parents, students, and the community-at-large are also important steps in attacking the problem. The major components of the school's antidrug effort, however, are early intervention and prevention activities. Although no one prevention approach has proven to be totally effective, programs based on the reasons students take drugs, such as social pressures, hold the most promise. When prevention and early intervention fail, schools should be prepared to refer students to professional drug treatment, and to support the student's re-entry and transition back to school after treatment.

School drug prevention and intervention programs that work and last have the following characteristics: one person in charge; their own budget and staff resources; and well-thought-out, consistently implemented policies and rules. They also are usually staffed by highly dedicated and enthusiastic people who receive strong support from the school's leadership and enjoy the trust of both school staff and members of the community. Successful prevention programs are also consistent from one school to another within the same school district (Towers, 1987).

THE IMPACT PROGRAM

The Impact Program is an example of an exemplary program currently in existence for K-12. It is a multifaceted substance abuse program that has evolved in the Newberg School District in Newberg, Oregon (Leatt, 1987). The Impact program uses the combined resources of schools, community leaders and professional instructors in a substance abuse prevention/intervention program.

Training for the Impact "core team" includes information on the physiology of drugs, counseling and interview techniques, and training in how to identify patterns of behavior typical of substance abusers. Topics such as dependency, how emotions are affected by drug abuse, the nature of drugs, the problems of adolescents, and role of the family are discussed. (See Resource Section for information on Impact training.)

Applicants are selected for the core team training based on their reasons for wanting to participate in the program and what role they can play after they have completed the training. The goal is to have at least one Impact-trained person in each of the eight schools in the district. The individuals associated with this program must have a strong desire to participate, and be credible to the students they will be working with.

The Identification Process

The process of identifying potential substance abusers involves the entire staff. The core team has designed a comprehensive form for use by the teaching staff which alerts them to changes in patterns of behavior, appearance and performance. Team members are not trained to diagnose or treat substance abuse, but to recognize behaviors. One does not have to be an expert, just willing to understand the behaviors associated with substance abuse, and more importantly, willing to take the important step of making the connection between the student and the Impact core team.

Once a teacher completes the student referral form it is sent to the Impact core team leaders who meet once a week to review referrals. If the core team leaders conclude that further observations are necessary, they send a similar form to all the student's teachers with the request that the referral form be completed confidentially. The core team then meets again to discuss and review the new information supplied by the teachers.

In reviewing the teacher referral sheets, the Impact core team looks for a general pattern. The team tries to determine whether the teachers' responses reflect significant changes in behavioral patterns.

As the core team proceeds with its evaluation of all the available information, it tries to determine whether the student needs assessment. If the answer is no, then the core team closes the referral until additional information warrants a new referral. Usually the team automatically reviews such cases every two months.

This referral system for identifying potential substance abusers is in use in the Newberg School District for all students in grades K-12. The referral form is designed to be comprehensive yet easy to use. A sample of this referral form is found in Appendix C.

Interview with the Family

If the team decides that an assessment is necessary, a conference is set up with the parents to attempt to gain acceptance of and support for their recommendations. The hope is that the parents will agree to have their child assessed. Because of the sensitive nature of the problem and the many ramifications of the identification of a substance abuser, it is essential that those involved in the interview process have a basic understanding of the law as it relates to chemical substance abuse. Statements made to parents must be carefully worded to avoid exposing the school to court action or liability for the cost of treatment. This is the step that can cause many schools to remain uninvolved.

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One way to begin interviews with parents is to focus on specific behaviors or patterns observed by teachers that relate to school activities. Such observations are a legitimate concern of schools and usually can be used to draw information from parents about any changes they may have observed in their child's behavior at home.

If the parents' responses confirm that the student needs an assessment, the counselor then suggests that the student be referred to an agency for an assessment. The parents are given the names of at least three assessment agencies which usually provide the service at no charge. This is another stage in the intervention process that requires current, stable information. It is also

helpful if the Impact team has a working relationship with members of these agencies. The key issue during this stage is enlisting the cooperation of parents without overwhelming or alienating them. The parents are a key element in the assessment process.

In most cases the student is not involved in the deliberations until the parents take him or her to an agency for assessment. At the high school, however, the counselors who are Impact trained confront the students who have been referred in an attempt to get them to acknowledge that they need help. Part of the intervention process is to place the students in a position where they have to acknowledge that their use of chemicals is interfering with their lives.

If the parents do not accept the recommendation of the Impact counselor regarding their son's or daughter's assessment, then the matter is closed in all cases except mandatory referrals, which come from administrators.

Treatment or Expulsion

Mandatory referrals normally arise when students are found in possession or under the influence of drugs or intoxicated by alcohol. In such cases the student and parents are given an alternative to immediate expulsion. If the family and student are willing to go ahead with an assessment and the necessary treatment, the expulsion will be held in abeyance pending the student's successful completion of treatment. Students who refuse to do this are in effect choosing to be expelled.

Transition Back to School

While in treatment, students literally breath, sleep, and eat recovery; gradually they begin to feel good about themselves. However, a student may come away from treatment with a more positive self-image only to return to a setting where peers and even teachers and counselors have not changed their perceptions. Unless the student's lifestyle is supported by friends, family and teachers, he or she can easily slip back into old ways of behavior. In addition, the students are faced with many school-related problems, including making up missed schoolwork and working to improve their attitude toward their teachers and school in general.

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The follow-up program offered through Impact is called Personal Development Support Group. It is a combination counseling/support group and academic class. Attendance is voluntary, although restricted to those students who have completed treatment. Some of the objectives of the program are:

- Working on problems identified in treatment,
- Making changes in lifestyle such as how to relate to others while clean and sober,
- Making friends and developing new relationships,
- Dealing with peer pressure to use alcohol and drugs (e.g., saying no without feeling uncomfortable),
- Dealing with other school and family stresses without using mood-altering drugs,
- Learning to take responsibility for the consequences of personal choices and behaviors.

Ground rules have been established for the Newburg support group. They are to:

- Participate in the group,
- Arrive on time every day,
- Stay straight,
- Abide by the group's established goals and objectives,
- Write their own recovery plan for their life and establish consequences for their life goals and actions.

The main feature of the Impact program is the definition of roles. Members of the Impact team come from all levels in the schools, as well as from the community. All members have had thorough training. Another strength of the program is the recovery support group. The program is based on a cooperative effort between faculty, staff, administrators and community members.

A 17-year-old high school junior was referred to the intervention program from the courts, after a DUI (driving under the influence) conviction. His school performance was deteriorating from straight A's and on more than one occasion he had been thrown off the hockey team for being drunk on the ice during practice. He was one of the team's stars and was being recruited by Ivy League Universities because of his high academic performance and extraordinary abilities in baseball and hockey. (Newton Youth Drug/Alcohol Program, 1983)

Schoolwide substance abuse prevention activities can start with a particular cross-section of students. With the high visibility and peer respect given athletes, school efforts targeted for this population can be effective. The Department of Justice, Drug Enforcement Administration published a packet of materials in 1986 aimed at high school coaches. A booklet titled *For Coaches Only: How to Start a Drug Prevention Program* challenges coaches to take advantage of their special relationship with young people. They are in contact with many of the opinion makers and status leaders of the school and have a tremendous impact on them. Coaches are encouraged to make sure that their athletes are not using, abusing or condoning the use of drugs or alcohol. It suggests that they make a survey to see exactly what the problem is, if one exists, among athletes in their school. Recent studies have shown that alcohol and drug use among student athletes may be very serious in certain schools. The booklet asks coaches first to find out how much they know about their players, to become aware of the problems, situations, and habits.

With the high visibility and peer respect given athletes, school efforts targeted for this population can be effective.

The second challenge is for coaches to do something about preventing drug problems on their teams. In particular they are told that they can:

- Make themselves knowledgeable, just like everyone else, about the symptoms of drug abuse and be able to recognize the signs;
- Call their captains together and talk about drug abuse;
- Open a dialogue with athletes on alcohol and drug abuse;
- Persuade the athletes in their school to use pressure on teammates to refrain from the use of drugs and alcohol;
- Enforce training rules and school regulations, sometimes better than others can;
- Advise athletes of the legal penalties of drug use;

- Develop a plan for dealing with drug abuse;
- Set up conferences with parents;
- Confront their players immediately when they smell alcohol or tobacco, or detect some other drug;
- Set a good example for the students.

For years, many coaches have suspected that some athletes may be using alcohol and other drugs. They probably have not known the extent of the problem.

Most coaches tend to underestimate the influence they can have on the young men and women who play for them. A coach is an authority figure for these students. They look up to the coach, who occupies a leadership role at a very significant period in their lives.

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The Drug Enforcement Administration also publishes a booklet called *Team Up for Drug Prevention*, a set of specific action plans that coaches can adopt. This packet of information includes the following printed material:

- The effects of drugs on young people,
- Reasons why athletes use alcohol and other drugs,
- Enabling behaviors for coaches (things coaches may or may not do that unwittingly support student drug use),
- Responsibilities of coaches regarding chemical abuse,
- Suggestions to coaches on starting a drug prevention program for athletes,
- Nine steps for drug prevention programs for athletes,
- Suggestions for captains when dealing with their teammates,
- Sample survey to give to athletes on their drug use,
- Sample letter to parents,
- Sample survey of coaches.

The activities enumerated in this packet are practical and simple, they require no money and little extra time, and they are appropriate to the coach's overall job description and responsibility (Towers, 1987).

An investigation by Donovan and Jessor (1978) indicated that drug problems begin early among the youth in the United States, increase continuously in each school year, and peak during students' collegiate and post-graduate years.

Young people of college age, in particular, may experiment with drugs as part of their exploration and growth. Students should not be prevented from learning boundaries through experience. Parental actions can drive unnecessary wedges between students and adult role models and force explorations of limits into even less healthy situations (Nelson, 1986).

Young people of college age, in particular, may experiment with drugs as part of their exploration and growth. Students should not be prevented from learning boundaries through experience.

In a 1987 study, Cherry proposed a social bond theory derived from a combination of control theory (Hirschi, 1969), and problem behavior proneness theory (Jessor, 1977), to provide information for substance abuse prevention planning on the college level.

Control theory is based on the assumption that the quality of the parent-child bond influences the child's decision to participate in deviant and delinquent activities. Problem-behavior proneness theory views behavior as the outcome of an interaction of personality and environmental influences. The theory is based on the concept that problem behaviors such as adolescent drinking, sexual experimentation, illicit drug use, and certain types of delinquency are related. Social-bond theory, then, becomes a relationship between the student and the college that functions in much the same way as the parent-child relationship.

Results from this study by Cherry indicate that students with strong bonds to the college community, religious institutions, and their families drank much less than did students with weak or broken bonds. The clear implication is that students with close ties to their community and who are involved in church and family are less likely to drink heavily than are those who are not so involved. (See Appendix D for a questionnaire to assess chemical dependency at the college and university level.)

Past drug prevention programs that have failed were most likely grounded in incorrect assumptions about why adolescents begin using psychoactive substances (Polich et al., 1984). Prevention programs offer more hope for reducing adolescent drug use than any other method. The object is to aim at the reduction, delay or prevention of drug use *before* it has become habitual or clearly dysfunctional.

Prevention programs offer more hope for reducing adolescent drug use than any other method. The object is to aim at the reduction, delay or prevention of drug use before it has become habitual or clearly dysfunctional.

Primary prevention is focused on the early stages - trying to keep young people from ever starting at all, or, if they have experimented, from shifting into regular use. Most primary prevention programs are aimed toward younger populations or groups of adolescents who have not been identified as having a drug use problem, and are not "at risk" for developing a problem (Goodstadt, 1981).

Secondary and tertiary prevention programs focus on preventing regular users from becoming habitual users or addicts. Secondary prevention programs target "at risk" populations who have not yet manifested drug use problems. Tertiary programs focus on those who have already manifested some problems associated with drug use, but who have not fallen into heavy use.

Secondary and tertiary prevention programs, face more difficult odds than primary prevention programs. There is now evidence to support the theory that the longer a person delays drug involvement, the more likely it is that he or she will be able to stop using in the future (Polich et al., 1984).

Types of Programs

Information-only programs may increase knowledge about drugs, but evidence does not suggest that they affect actual behavior. Some have even claimed that these programs cause increased drug use (Polich et al., 1984). The main assumption underlying most of these programs is the belief that a change in attitude will lead to a change in behavior. This assumption may be a faulty one. Additionally, many of the information programs have suffered from questionable implementation practices. Some exaggerated the negative consequences of drug use and lost their credibility with adolescents (Polich et al., 1984).

Affective education programs focus on such things as values-clarification, improving self-esteem and decision-making skills. An inherent weakness in these programs is that they are

extremely difficult to implement. The goal of many of these programs is to try to affect a change in self-concept—something that is the product of the adolescent's entire life experience. Evidence that short-term programs can raise self-esteem is limited and current research is questioning the relationship between low self-esteem and the onset of drug use (Kandel, Kessler, & Margubes, 1978; Kovach & Glickman, 1986).

Values clarification is another area that is difficult to implement. It simply is not clear which values are associated with specific drug behaviors, or what the connection is between a particular value change and a particular behavior change.

Most programs do not link general skills in communication or decision-making with specific drug situations. In fact, helping adolescents to improve these important skills might be very helpful, as kids need specific information on what they should do when a friend offers them marijuana or other drugs and they wish to refuse.

Englander-Golden, Elconon, Miller and Schwargkoff (1986) report that youngsters say yes when they want to say no and this especially occurs most often if they fear rejection, not being liked, or losing a friend.

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Schools can be of assistance to high risk students and families in several ways. Special programs for high risk children have been developed based on the employee assistance program model (Morehouse, 1979). These special programs begin as specialized educational curricula at the elementary level and progress to education plus intervention and referral for treatment, as needed, at the secondary level. It is in the best interest of schools to provide special programs, in addition to the regular classroom program, so that high risk children have the opportunity to understand their circumstances and make decisions that could lower their risk for substance abuse. Schools can also be the focal point for parental programs that teach enhanced family communications and other skills (Bry, 1982; Hawkins et al., 1985).

Making available the best drug education curricula based on the correct assumptions about why adolescents begin using psychoactive substances is not enough. The factors that contribute to adolescent drug abuse are too complex. Steps must also be taken to ensure that community support remains consistent and leads to a variety of school based and non-school based programs available and accessible to all pre-adolescents and adolescents (Bry, 1982; Perry & Jessor, 1985).

Curriculum development is the necessary first stage of drug education, but inservice training programs to prepare teachers to implement new curricula are also essential (Lohrmann & Fors, 1986). Even the best curriculum will have minimal effects in the hands of poorly trained teachers (Connell, Turner, & Mason, 1985).

Curricula for the Prevention of Substance Abuse

Historically, drug abuse prevention programs were based on the assumption that children and adolescents experimented with drugs because they were ignorant of the consequences of drug use. Such ignorance, it was reasoned, resulted in neutral or even favorable attitudes toward experimentation and/or regular use. Now we understand that drug abuse is associated with a variety of social, intrapersonal, and behavioral factors as well.

Most health education curricula today are, therefore, a great deal more comprehensive. Sample curricula and materials are available from state education departments, local school systems, public and private agencies, and commercial educational text and materials publishers. Most of them are based on the research that emphasizes self-esteem, decision-making and refusal skills, and pertinent information about the effects of drugs. And almost all begin at an earlier age (Miller, 1988; Towers, 1987).

Curriculum materials and instructional media useful for drug and alcohol prevention are more plentiful today than ever before.

Curriculum materials and instructional media useful for drug and alcohol prevention are more plentiful today than ever before. In addition to the various commercial materials, a number of short courses and/or materials are available from government agencies and public service groups, many of them free of charge. (See the resource section for a list of some of these programs.)

There is no single cause of drug abuse and no single, or best way, to prevent it. Although today's drug and alcohol abuse prevention efforts are largely based on current research, as frequently happens, research offers contradictory messages. Therefore, professionals involved in drug abuse prevention programs must rely on their experience and common sense as well as the latest research.

The following are four recommendations for those in charge of planning and implementing substance abuse prevention programs in the public schools.

Use a broad-based approach.

- Deter drug use by limiting the availability of drugs on and around school property and imposing stiff and consistently enforced penalties for use, possession, and distribution;
- Continue to provide information on the effects of drugs in a factual manner, emphasizing their short-term or immediate physical and social effects;
- Provide social skills training, including how to cope with social pressures to use drugs, and how to analyze the consequences of individual choices and identify alternative behaviors consistent with the individual's value system;
- Cooperate with the home and other agencies to provide more responsible and age-appropriate alternative activities that help youngsters increase their bonds with school, family, and community.

Prevention efforts should begin before youngsters are age 12 and faced with hard decisions. Putting prevention programs in place in elementary schools is critical.

Start prevention activities early. According to many experts early age of drug use onset is the best predictor of serious abuse (U.S. Dept. of Education, 1986). Prevention efforts should begin before youngsters are age 12 and faced with hard decisions. Putting prevention programs in place in elementary schools is critical. Also, special efforts should be made to bolster prevention activities during especially traumatic and vulnerable times, e.g., just before the transitions to middle school and to senior high school.

Help high-risk students first. We know from research, experience, and common sense that some kids are at greater risk of becoming drug abusers than others. Sometimes these children exhibit their vulnerability early in their school career, but more often they are noticed in middle school and senior high school. This is not to say that prevention programs should not be offered to all students. When students are identified as being at high risk, they should be given additional help immediately. Some risk factors to look for include the following:

- Poor parent-child relationship, including parental withdrawal of love, or abuse and neglect;
- Delinquency, disruptiveness, rebelliousness, or alienation;
- Low academic motivation;

- High degree of independence, and tolerance for risk-taking behavior;
- High degree of family and/or peer misuse of drugs;
- Early cigarette use;
- Psychological disturbance;
- Note that these factors appear to increase the probability of subsequent drug abuse. They should not be confused with factors indicating current drug use.

Cover all bases. Prevention efforts should be a continuum of interrelated and complementary activities including those at school, at home, and in the community. They should begin with preschool and continue through high school and beyond. Prevention efforts must extend beyond information and awareness to social-environmental, interpersonal, and behavioral factors. Since children become involved with drugs by starting with "gateway" substances such as tobacco and alcohol, we must concentrate early in students' lives on showing them the dangers in using these harmful substances. Everyone's help should be enlisted, including that of successful non-drug-using students who can serve as positive peer role models (Silverman, 1987).

Since children become involved with drugs by starting with "gateway" substances such as tobacco and alcohol, we must concentrate early in students' lives on showing them the dangers in using these harmful substances.

These recommendations apply to teachers, parents, counselors and, to an increasing extent, peers. Planners of prevention programs must consider the merits of involving each of these groups. The real key is the existence of a coordinated continuum for monitoring and assessing changes in students' behavior. This type of program provides an avenue for counselors, teachers and peers to be involved in diagnosis of probable substance abuse problems. Teachers and peers become resources, who because of their day-to-day involvement with students are able to put up flags of warning when they see changes.

Counselors can then make the decision of whether or not this particular student must be assessed, and/or treated for substance abuse problems. They have the resources for developing liaisons with agencies outside of the school.

The business world can play a valuable role in community-based substance abuse prevention programs. In addition to financial support, business and industry can also provide considerable expertise. For example, business leaders can be invited to forum discussions, where students can hear how substance abuse affects employment.

Sport stars who speak out for healthy living and saying no to drugs can also serve as models for students.

The media can reinforce the efforts of the school by playing an important role in the promotion of drug awareness education.

It is also helpful to organize presentations for parents and the community to make them aware of the information the students are receiving in school.

The following are some basic guidelines for those responsible for organizing presentations for parents and the community:

- Use only current and valid information;
- Don't use scare tactics; they may make an impact initially, but have virtually no lasting effect on future decision-making;
- Be aware that effective drug education both raises questions and provides answers;
- The ability to think critically and to make decisions based on facts rather than opinions is a skill that can help students to make wise choices about using drugs;
- Substance abuse education must be a part of the total curriculum because it involves all subjects and all grade levels.

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Gaining Community Involvement for Prevention Programs

Contacting community drug abuse centers and asking recovering addicts to give "how it was for me" presentations can be a helpful tool. However, planners must carefully monitor this type of program. Some recovering addicts may glamorize the lifestyle, and others may admit they are still taking drugs.

Careful screening of recovered drug abusers is extremely important. In fact, anyone who is a potential speaker to students on this topic should be screened first to determine that (1) they do not currently use drugs or intend to use them; (2) their attitude toward drug use by students is appropriate to the purpose of a prevention activity; and (3) they are articulate, willing to participate, and likely to profit from the experience themselves. Presentations by recovered abusers who speak well and are sincere and intelligent can be a positive influence in dissuading students from experimenting. Done in a haphazard or unplanned manner, this type of activity can do more harm than good.

Inviting adolescents who are currently in drug treatment programs to speak at faculty meetings can be a productive activity. At such meetings recovering addicts share how and why they

started using drugs, what drugs they abused and how often, and if and how they used drugs before or during school hours. Teachers are usually particularly interested in students' perceptions of what their teachers thought about their drug use and whether they believed that the teachers were aware of it. In addition, most faculty find it valuable to hear students share their feelings about whether their teachers cared about them and what they could have done to help.

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A Framework for Program Planning

Jessor's research (1977) on the problem behavior of adolescents has identified variables which influence the initiation of adolescent drug use. Lohrmann and Fors (1986) have integrated Jessor's findings into a framework using the PRECEDE model of health education planning (Green, 1987). The PRECEDE model includes three categories of factors that can influence whether individuals adopt and practice positive health behaviors. These include *predisposing factors, enabling factors, and reinforcing factors*. Predisposing factors include knowledge, beliefs, values, attitudes, and generally the (stuff) a person brings into (the situation). Enabling factors include availability and accessibility of health resources, community commitment to health, and health-related skills. Reinforcing factors include family, teachers, peers and health providers.

The integration of Jessor's findings with the PRECEDE model led to the following hypotheses of what should be addressed in a substance abuse prevention program:

1. Predisposing Factors
    - high value for compliance over independence,
    - high value and expectation for school achievement,
    - high value for moral and spiritual development.
2. Enabling Factors
    - availability and accessibility of programs,
    - demonstrated commitment from the community.
3. Reinforcing Factors
    - high parental support (and control),
    - high parental and peer disapproval of drug abuse,
    - low level of parental drug use.

Translating broad educational objectives . . . into a meaningful program that becomes part of a school's curriculum is a lengthy task that requires drawing on the resources of both the school and the community.

According to Lohrmann and Fors (1986), the probability for success for health education programs is increased by the extent to which each category is addressed.

Translating broad educational objectives such as these into a meaningful program that becomes part of a school's curriculum is a lengthy task that requires drawing on the resources of both the school and the community. In the Newberg, Oregon Impact Program, people from all walks of life are on the curriculum committee. Teachers, counselors, and administrators from each of the elementary, middle, and high schools all worked together with members of the community to create the substance abuse awareness program for the district.

A piecemeal approach, in which programs at the elementary, middle, and high schools are developed independently is not likely to be very effective. In order to achieve a balanced, coordinated program, a systematic plan of action for all grade levels must be formulated. Most effective substance abuse education is cumulative, and each district is likely to have its own special emphasis. Using outside agencies and other professionals as well as school personnel will also make the program more effective.

THE DISEASE CONCEPT OF ALCOHOLISM

The definition of deviant behavior varies from one social group to another. It is not the act but the definition of the act that makes it deviant. Conrad and Schneider (1980) describe how various forms of deviance have changed in their definitions over the years from "badness" to sickness with the expansion of medicine as an agent of social control. They speak of this as the medicalization of deviance.

Alcoholism provides a good example of the medicalization of deviance in the United States. A concerted attempt has been made, especially in the 1940s and 1950s, to change the view of alcoholism from that of morally wrong behavior caused by a character weakness for which the individual is held responsible, to that of an illness over which the individual has little, if any, control and thus diminished responsibility. Alcoholics Anonymous, the Yale Center for Alcohol Studies, and the National Council on Alcoholism have been the leading private lobbyists for the disease concept of alcoholism in the United States (Conrad & Schneider, 1980; Davis & Anderson, 1983). Additionally, the American Medical Association, the U.S. Government's National Institutes of Health and the World Health Organization's Expert Committee on Mental Health have defined alcoholism as a disease. The official labeling of alcoholism as an illness has had certain ramifications such as the removal of simple drunkenness from the list of criminal offenses, medical insurance payments for the treatment of alcoholism (Ries, 1978), change in public attitude toward alcoholism, and to a considerable extent the removal of the responsibility of the alcoholic for his/her behavior (Roman & Trice, 1968).

A concerted attempt has been made, especially in the 1940s and 1950s, to change the view of alcoholism from that of morally wrong behavior caused by a character weakness for which the individual is held responsible, to that of an illness over which the individual has little, if any, control and thus diminished responsibility.

Perceptions of drug addiction in the United States have had a somewhat different history. In the late 1800s drug addiction was considered a medical matter and was not viewed in a moralistic way. Later, through legislation, it became criminalized, and today we are left with a hybrid-medical designation of drug addiction (Conrad & Schneider, 1980; Goode, 1978).

A change in the public's definition of alcoholism has contributed to a change in the perception of alcoholism in the United States. Various studies of the public's definition of alcoholism over the past few years have dealt with adult populations and indicate that 50 to 66 percent of study participants accept the medical model of alcoholism as an illness (Haberman & Scheinberg, 1969; Mulford & Miller, 1964; Ries, 1977; Rodin, 1981).

More young people consider drug addiction an illness than consider alcoholism an illness. However, less than 50 percent of young people consider either to be an illness.

However, a study by Lorch and Hughes (1986) revealed that there is low acceptance among youth of the medical model of alcoholism and drug addiction. More young people consider drug addiction an illness than consider alcoholism an illness. However, less than 50 percent of young people consider either to be an illness.

Those youth who did define alcoholism as an illness were younger; and those who defined both alcoholism and drug addiction as an illness did not have an alcoholic or drug addict as a family member. Also, they had never tried drugs or alcohol or had tried them but quit. Young people who have less personal experience with and knowledge of alcohol and drugs are more likely to accept professional, objective definitions of alcoholism and drug addiction. On the other hand, those who have first-hand experience with alcohol or drug use (either because they are a substance abuser or have a family member who is a substance abuser) usually define alcoholism and drug addiction as due to immorality or lack of will power (high individual responsibility), rather than as an illness (no or diminished individual responsibility).

From the viewpoint of counselors the issue is one of responsibility. One of the reasons a debate still exists over the definition of substance abuse is that it does not fit neatly into either a disease or behavioral category. In light of current research it is difficult to argue against genetic, physiological or behavioral components when attempting to understand the dynamics of alcohol abuse. However, it is dangerous to adopt a strict interpretation of the disease model because it can be interpreted as an *excuse* for behavior. We have come a long way from thinking of alcoholism as a moral or character defect. The weight of current research suggests psysiological determinants. But because of the prevelance of denial, which prohibits substance abusing individuals from realizing that a problem exists, the issue of responsibility for behavior remains complex. An individual may engage in years of destructive behavior with questionable chance of recovery, and then complete a treatment program, only to become part of a majority that experience relapse.

Alcoholism has been compared with many diseases including adult-onset diabetes. Some individuals may be prone to adult-onset diabetes, but never actually become diabetic because they follow a particular diet and exercise routine. Others might

progress from needing oral medication to daily insulin injections because they did not control their diet.

Further parallels can be made between social enticements for drinking alcohol and eating sugar. In both instances individuals know that their bodies cannot handle the substance; they must repeatedly find ways of saying "No" to the substance.

Obviously it can be argued that one drink is far more devastating to an alcoholic than a cookie to a diabetic. But the point can nonetheless be made that the "afflicted" person can still exercise control over his or her behavior.

Major differences also include the following:

- No preventive or ameliorating injection can be given to an addict.
- Harmful and destructive behavior and much personal turmoil are characteristic of the lives of alcoholics. Frequently, alcoholism is devastating to family life and can lead to the loss of one's job.
- Alcoholics characteristically practice denial which is a real barrier to self-awareness and the ability to make the choice to quit drinking.

From a treatment point of view, many have found it helpful to adopt the disease concept for alcoholism. From a philosophical point of view, there remains the unsolved question of responsibility.

Alcoholics characteristically practice denial which is a real barrier to self-awareness and the ability to make the choice to quit drinking.

CONCLUSION

The importance of prevention and early intervention regarding substance abuse cannot be overemphasized. "Passing the buck" and fear of involvement are not acceptable excuses. Teachers will continue to play a crucial role on the team of professionals who adolescents associate with daily. It can be argued that teachers have a moral responsibility to intervene in the lives of students who are substance abusers because the problem, if left unrecognized, will in most cases get worse.

Many adults can now play a big part in the prevention of the destruction caused by substance abuse. One does not have to be trained as a counselor to recognize signs and symptoms. Intuition is a valuable tool. Adults just need an established channel for referral and assessment, and a sense of responsibility.

Schools cannot do it all. After all, their primary purpose is to teach. Nonetheless, students spend a great deal of their time in school, and school personnel are at a great vantage point for noticing questionable behaviors. If programs can be established at the school-district level (this may take some lobbying from parents, teachers, and students at the community level), then at least an avenue for early intervention (and even late intervention) will exist.

Schools cannot do it all. After all, their primary purpose is to teach. Nonetheless . . . school personnel are at a great vantage point for noticing questionable behaviors.

APPENDIX A: CRACK COCAINE

Crack is cocaine in smokable (freebase) form. People have been smoking freebase for some time. However, before Crack, they had to convert cocaine into freebase with highly flammable chemicals. Now dealers have found a "safe" way to convert cocaine into freebase, using ammonia or baking soda and water. The result is crack. The name comes from the crackling sound it makes when smoked.

Dealers "cook" crack in kitchens, ending up with what looks like shavings or chips scraped from a bar of soap, which is then packaged in small plastic vials that sell for $10 to $20 each. Users sometimes pulverize the chips, sprinkle them on a tobacco or marijuana cigarette and smoke them. Crack is also vaporized and smoked through the stem of a specially designed glass pipe.

Crack is the most potent and toxic form of cocaine available, and is five to ten times as addictive as cocaine taken in other forms. Cocaine is generally 15 to 25 percent pure, while crack is often 90 percent pure. It reaches the brain in six seconds, producing an instant high which lasts six to eight minutes.

Physiologically crack triggers an explosive release of neurotransmitters in the brain, rapidly depleting the brain's supply of these natural substances and producing an intense craving for more stimulation. The user takes more crack to satisfy a craving that can never be fulfilled.

The Crack Epidemic

Until the end of 1985, few had even heard of crack. Now it is used by at least one million people in 25 states. Crack addicts now account for 75 to 80 percent of those seeking treatment in major cities.

Most sellers and buyers are in their 20's and 30's, but more and more teenagers are becoming involved with this drug. Children as young as eight and nine are being introduced to crack by older brothers and sisters or friends.

Detroit authorities report that 13 to 15-year-old children have $50-dollar-a-day crack habits. Because youthful offenders draw lighter sentences, crack dealers use teenage boys to distribute the drug. The result is a major drug ring in Detroit called Young Boys Inc. Officials describe Young Boys as hardened criminals who carry guns and who will kill to protect their individual street corners.

Psychological Dangers

Crack is almost instantly addicting. Epidemiologists interviewed a 16-year-old girl who reported her entire life was focused on crack. The interview took place on a Friday. The girl first used crack the previous Monday.

As the addiction takes hold, the user experiences memory problems, insomnia, fatigue, depression, paranoia, irritability, loss of sexual drive, suicide ideation and violent behavior. Crack becomes the most important thing in the user's life and overpowers other needs such as eating, sex, family life, personal health and career.

Many crack users are also addicted to alcohol, tranquilizers and other drugs taken to relieve the unpleasant side effects of crack.

Crack Houses

Crack houses are springing up in cities where the drug is out of control. An 80's version of opium dens, these houses offer users a place to smoke crack until their money runs out.

Some spend hours, others days, maintaining a constant high, never eating, never sleeping, caring only about the next dose. Crack users sell everything they can get their hands on - other people's belongings, their own bodies, anything that will bring in more cash for more crack.

One expert described how severe the addiction to crack can be. He told of robbers who entered a crack house, shot the proprietor dead and told the two dozen or so crack users present to freeze. In such a life-threatening situation, four crack users nonetheless continued to smoke the drug while the robbery transpired.

Signs and Symptoms of Use

Psychological Symptoms

Profound personality changes;
Confusion, anxiety, depression;
Irritability, short temperedness;
Restlessness, lethargy;

Suspiciousness of friends, loved ones, co-workers;
Impaired thinking;
Difficulty in concentrating, remembering;
Weakness, lassitude;
Neglect of work, other responsibilities;
Loss of interest in food and sex;
Aggression, panic attacks;
Delusions, paranoia, violence;
Visual, auditory or tactile hallucinations.

Physical Symptoms

Seizures, epilepsy;
Chest pain;
Constantly running nose;
Nasal burns and sores;
Sore throats, hoarseness;
Shortness of breath, cold sweats, tremors;
Malnutrition, severe weight loss;
Insomnia, inability to sleep;
Neglect of personal hygiene;
Singed eyelashes and eyebrows.

Street Names for Crack

Base, Baseball, Black Rock, Cloud Nine,* Conan,* Crack Crank, Freebase, Gravel, Handball,* Lido,* Rock Roxanne, Serpico,* Snow Toke, Space Basing (crack doused with liquid PCP and smoked; also called ghostbusters), Super White*, White Cloud*, White Tornado.

*Brand names certain dealers sell.

Note: Adapted from a pamphlet by Families in Action, Inc., 1986.

Specific Drugs and Their Effects

CANNABIS

Effects

All forms of cannabis have negative physical and mental effects. Several regularly observed physical effects of cannabis are a substantial increase in the heart rate, bloodshot eyes, a dry mouth and throat, and increased appetite.

Use of cannabis may impair or reduce short-term memory and comprehension, alter sense of time, and reduce ability to perform tasks requiring concentration and co-ordination, such as driving a car. Research also shows that students do not retain knowledge when they are "high." Motivation and cognition may be altered, making the acquisition of new information difficult. Marijuana can also produce paranoia and psychosis.

Because users often inhale the unfiltered smoke deeply and then hold it in their lungs as long as possible, marijuana is damaging to the lungs and pulmonary system. Marijuana smoke contains more cancer-causing agents than tobacco.

Long-term users of cannabis may develop psychological dependence and require more of the drug to get the same effect. The drug can become the center of their lives.

Type	What is it called?	What does it look like?	How is it used?
Marijuana	Pot Grass Weed Reefer Dope Mary Jane Sinsemilla Acapulco Gold Thai Sticks	Dried parsley mixed with stems that may include seeds	Eaten Smoked
Tetrahydro-cannabinol	THC	Soft gelatin capsules	Taken orally Smoked
Hashish	Hash	Brown or black cakes or balls	Eaten Smoked
Hashish Oil	Hash Oil	Concentrated syrupy liquid varying in color from clear to black	Smoked—mixed with tobacco

From *What Works: Schools Without Drugs* by U.S. Department of Education, 1986.

HALLUCINOGENS

Effects

Phencylidine (PCP) interrupts the functions of the neocortex, the section of the brain that controls the intellect and keeps instincts in check. Because the drug blocks pain receptors, violent PCP episodes may result in self-inflicted injuries.

The effects of PCP vary, but users frequently report a sense of distance and estrangement. Time and body movement are slowed down. Muscular coordination worsens and senses are dulled. Speech is blocked and incoherent.

Chronic users of PCP report persistent memory problems and speech difficulties. Some of these effects may last 6 months to a year following prolonged daily use. Mood disorders—depression, anxiety, and violent behavior—also occur. In later stages of chronic use, users often exhibit paranoid and violent behavior and experience hallucinations.

Large doses may produce convulsions and coma, heart and lung failure, or ruptured blood vessels in the brain.

Lysergic acid (LSD), mescaline, and psilocybin cause illusions and hallucinations. The physical effects may include dilated pupils, elevated body temperature, increased heart rate and blood pressure, loss of appetite, sleeplessness, and tremors.

Sensations and feelings may change rapidly. It is common to have a bad psychological reaction to LSD, mescaline, and psilocybin. The user may experience panic, confusion, suspicion, anxiety, and loss of control. Delayed effects, or flashbacks, can occur even after use has ceased.

Type	What is it called?	What does it look like?	How is it used?
Phencyclidine	PCP Angel Dust Loveboat Lovely Hog Killer Weed	Liquid Capsules White crystalline powder Pills	Taken orally Injected Smoked—can be sprayed on cigarettes, parsley, and marijuana
Lysergic Acid Diethylamide	LSD Acid Green or Red Dragon White Lightning Blue Heaven Sugar Cubes Microdot	Brightly colored tablets Impregnated blotter paper Thin squares of gelatin Clear liquid	Taken orally Licked off paper Gelatin and liquid can be put in the eyes
Mescaline and Peyote	Mesc Buttons Cactus	Hard brown discs Tablets Capsules	Discs—chewed, swallowed, or smoked Tablets and capsules—taken orally
Psilocybin	Magic mushrooms Mushrooms	Fresh or dried mushrooms	Chewed and swallowed

DEPRESSANTS

Effects

The effects of depressants are in many ways similar to the effects of alcohol. Small amounts can produce calmness and relaxed muscles, but somewhat larger doses can cause slurred speech, staggering gait, and altered perception. Very large doses can cause respiratory depression, coma, and death. The combination of depressants and alcohol can multiply the effects of the drugs, thereby multiplying the risks.

The use of depressants can cause both physical and psychological dependence. Regular use over time may result in a tolerance to the drug, leading the user to increase the quantity consumed. When regular users suddenly stop taking large doses, they may develop withdrawal symptoms ranging from restlessness, insomnia, and anxiety to convulsions and death.

Babies born to mothers who abuse depressants during pregnancy may be physically dependent on the drugs and show withdrawal symptoms shortly after they are born. Birth defects and behavioral problems also may result.

Type	What is it called?	What does it look like?	How is it used?
Barbiturates	Downers Barbs Blue Devils Red Devils Yellow Jacket Yellows Nembutal Seconal Amytal Tuinals	Red, yellow, blue, or red and blue capsules	Taken orally
Methaqualone	Quaaludes Ludes Sopors	Tablets	Taken orally
Tranquilizers	Valium Librium Equanil Miltown Serax Tranxene	Tablets Capsules	Taken orally

STIMULANT: COCAINE

Effects

Cocaine stimulates the central nervous system. Its immediate effects include dilated pupils and elevated blood pressure, heart rate, respiratory rate, and body temperature. Occasional use can cause a stuffy or runny nose, while chronic use can ulcerate the mucous membrane of the nose. Injecting cocaine with unsterile equipment can cause AIDS, hepatitis, and other diseases. Preparation of freebase, which involves the use of volatile solvents, can result in death or injury from fire or explosion. Cocaine can produce psychological and physical dependency, a feeling that the user cannot function without the drug. In addition, tolerance develops rapidly.

Crack or freebase rock is extremely addictive, and its effects are felt within 10 seconds. The physical effects include dilated pupils, increased pulse rate, elevated blood pressure, insomnia, loss of appetite, tactile hallucinations, paranoia, and seizures.

The use of cocaine can cause death by disrupting the brain's control of the heart and respiration.

Type	What is it called?	What does it look like?	How is it used?
Cocaine	Coke Snow Flake White Blow Nose Candy Big C Snowbirds Lady	White crystalline powder, often diluted with other ingredients	Inhaled through nasal passages Injected Smoked
Crack or cocaine	Crack Freebase rocks Rock	Light brown or beige pellets—or crystalline rocks that resemble coagulated soap; often packaged in small vials	Smoked

OTHER STIMULANTS

Effects

Stimulants can cause increased heart and respiratory rates, elevated blood pressure, dilated pupils, and decreased appetite. In addition, users may experience sweating, headache, blurred vision, dizziness, sleeplessness, and anxiety. Extremely high doses can cause a rapid or irregular heartbeat, tremors, loss of coordination, and even physical collapse. An amphetamine injection creates a sudden increase in blood pressure that can result in stroke, very high fever, or heart failure.

In addition to the physical effects, users report feeling restless, anxious, and moody. Higher doses intensify the effects. Persons who use large amounts of amphetamines over a long period of time can develop an amphetamine psychosis that includes hallucinations, delusions, and paranoia. These symptoms usually disappear when drug use ceases.

Type	What is it called?	What does it look like?	How is it used?
Amphetamines	Speed Uppers Ups Black Beauties Pep Pills Copilots Bumblebees Hearts Benzedrine Dexedrine Footballs Biphetamine	Capsules Pills Tablets	Taken orally Injected Inhaled through nasal passages
Methamphetamines	Crank Crystal Meth Crystal Methedrine Speed	White powder Pills A rock which resembles a block of paraffin	Taken orally Injected Inhaled through nasal passages
Additional Stimulants	Ritalin Cylert Preludin Didrex Pre-State Voranil Tenuate Tepanil Pondimin Sandrex Plegine Ionamin	Pills Capsules Tablets	Taken orally Injected

INHALANTS

Effects

Immediate negative effects of inhalants include nausea, sneezing, coughing, nosebleeds, fatigue, lack of coordination, and loss of appetite. Solvents and aerosol sprays also decrease the heart and respiratory rates, and impair judgment. Amyl and butyl nitrite cause rapid pulse, headaches, and involuntary passing of urine and feces. Long-term use may result in hepatitis or brain hemorrhage.

Deeply inhaling the vapors, or using large amounts over a short period of time, may result in disorientation, violent behavior, unconsciousness, or death. High concentrations of inhalants can cause suffocation by displacing the oxygen in the lungs or by depressing the central nervous system to the point that breathing stops.

Long-term use can cause weight loss, fatigue, electrolyte imbalance, and muscle fatigue. Repeated sniffing of concentrated vapors over time can permanently damage the nervous system.

Type	What is it called?	What does it look like?	How is it used?
Nitrous Oxide	Laughing gas Whippets	Propellant for whipped cream in aerosol spray can Small 8-gram metal cylinder sold with a balloon or pipe (buzz bomb)	Vapors inhaled
Amyl Nitrite	Poppers Snappers	Clear yellowish liquid in ampules	Vapors inhaled
Butyl Nitrite	Rush Bolt Locker room Bullet Climax	Packaged in small bottles	Vapors inhaled
Chlorohydrocarbons	Aerosol sprays	Aerosol paint cans Containers of cleaning fluid	Vapors inhaled
Hydrocarbons	Solvents	Cans of aerosol propellants, gasoline, glue, paint thinner	Vapors inhaled

DESIGNER DRUGS

Effects

Illegal drugs are defined in terms of their chemical formulas. To circumvent these legal restrictions, underground chemists modify the molecular structure of certain illegal drugs to produce analogs known as designer drugs. These drugs can be several hundred times stronger than the drugs they are designed to imitate.

The narcotic analogs can cause symptoms such as those seen in Parkinson's disease—uncontrollable tremors, drooling, impaired speech, paralysis, and irreversible brain damage. Analogs of amphetamines and methamphetamines cause nausea, blurred vision, chills or sweating, and faintness. Psychological effects include anxiety, depression, and paranoia. As little as one dose can cause brain damage. The analogs of phencyclidine cause illusions, hallucinations, and impaired perception.

Type	What is it called?	What does it look like?	How is it used?
Analogs of Fentanyl (Narcotic)	Synthetic Heroin China White	White powder resembling heroin	Inhaled through nasal passages Injected
Analogs of Meperidine (Narcotic)	Synthetic Heroin MPTP (New Heroin) MPPP PEPAP	White powder	Inhaled through nasal passages Injected
Analogs of Amphetamines and Methamphetamines (Hallucinogens)	MDMA (Ecstasy, XTC, Adam, Essence) MDM STP PMA 2, 5-DMA TMA DOM DOB	White powder Tablets Capsules	Taken orally Injected Inhaled through nasal passages
Analogs of Phencyclidine (PCP) (Hallucinogens)	PCPy PCE TCP	White powder	Taken orally Injected Smoked

NARCOTICS

Effects

Narcotics initially produce a feeling of euphoria that often is followed by drowsiness, nausea, and vomiting. Users also may experience constricted pupils, watery eyes, and itching. An overdose may produce slow and shallow breathing, clammy skin, convulsions, coma, and possibly death.

Tolerance to narcotics develops rapidly and dependence is likely. The use of contaminated syringes may result in diseases such as AIDS, endocarditis, and hepatitis. Addiction in pregnant women can lead to premature, stillborn, or addicted infants who experience severe withdrawal symptoms.

Type	What is it called?	What does it look like?	How is it used?
Heroin	Smack Horse Brown Sugar Junk Mud Big H Black Tar	Powder, white to dark brown Tar-like substance	Injected Inhaled through nasal passages Smoked
Methadone	Dolophine Methadose Amidone	Solution	Taken orally Injected
Codeine	Empirin compound with Codeine Tylenol with Codeine Codeine Codeine in cough medicines	Dark liquid varying in thickness Capsules Tablets	Taken orally Injected
Morphine	Pectoral syrup	White crystals Hypodermic tablets Injectable solutions	Injected Taken orally Smoked
Meperidine	Pethidine Demerol Mepergan	White powder Solution Tablets	Taken orally Injected
Opium	Paregoric Dover's Powder Parepectolin	Dark brown chunks Powder	Smoked Eaten
Other Narcotics	Percocet Percodan Tussionex Fentanyl Darvon Talwin Lomotil	Tablets Capsules Liquid	Taken orally Injected

APPENDIX C: UNIVERSITY ALCOHOL AND DRUG QUESTIONNAIRE

With the aid of the enclosed questionnaire, we hope to learn more about the needs of our alcohol and drug related services here at the University. We ask that you take 20 minutes to carefully complete the questions below and then mail your survey to Integrated Research Services, Inc. by **April 10, 1986.**

We are grateful for your participation in this study. Your answers are strictly confidential. We have taken extensive measures to guarantee respondent anonymity and for that reason we ask you not to write your name on any part of the questionnaire.

Thanks again for your help. If you have any questions, please feel free to call Integrated Research Services, Inc., (503) 683-9278.

Fill in the number which applies to you in the space beside the question.

A. Background

1. Your sex: 1. Male 2. Female _____

2. Your age (write in): _____

3. Marital status:
   1. Single 2. Married 3. Separated 4. Divorced
   5. Widow/Widower 6. Single, but living with mate _____

Students Only (Others Skip to Question 9)

4. Your concentration:
   1. Social science 2. Arts/Humanities 3. Science
   4. Engineering 5. Independent 6. Other _____ (write in) _____

5. Year in school:
   1. Freshman 2. Sophomore 3. Junior
   4. Senior 5. Graduate 6. Other _____ (write in) _____

6. Do you live:
   1. In campus housing
   2. In an off-campus apartment
   3. In a residential fraternity or sorority house
   4. With your parents _____

7. Are you a fraternity or sorority member? 1. Yes 2. No _____

Adapted from R. Engs Student Alcoholic Questionnaire: ©Ruth C. Engs, HPER, Indiana University, Bloomington, IN 47405, 1975.
Adapted from ©Steven A. Bloch and Steven Ungerleider, Integrated Research Services, Irvine, CA, March, 1986 as adapted from Engs' S.A.Q.

8. Are you in good academic standing? 1. Yes 2. No _____

Faculty and Staff Only (Others Skip to Section B)

9. Job title:
   1. Professor 2. Instructor 3. Clerical/Administrative
   4. Other _____ (write in) _____
10. How many years have you been employed at the University? (write in) _____

B. We Would Like to Ask You about Your Patterns of Drinking and Using Drugs

1. Let's first take beer. How often, on the average, do you **usually** have a beer? (If you do not drink beer at all, place a "0" in the space provided and go to question 3.)
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. more than once a year but less than once a month
   5. once a year or less _____
2. When you drink beer, how much, on the average do you **usually** drink at any one time?
   1. more than 1 six pack (6 or more cans or tavern glasses)
   2. 5 or 6 cans of beer or tavern glasses
   3. 3 or 4 cans of beer or tavern glasses
   4. 1 or 2 cans of beer or tavern glasses _____
3. Now let's look at table wine. (If you do not drink wine at all, place a "0" in the space provided and go to question 5.) How often do you usually drink wine?
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. more than once a year but less than once a month
   5. once a year or less _____
4. When you drink wine how much, on the average, do you usually drink at any one time?
   1. over 6 wine glasses
   2. 5 or 6 wine glasses
   3. 3 or 4 wine glasses
   4. 1 or 2 wine glasses
   5. less than 1 glass of wine _____

5. Next we would like to ask you about liquor or spirits, (whiskey, gin, vodka, mixed drinks, etc.). (If you do not drink liquor at all, place a "0" in the space provided and go to question 7.) How often do you usually have a drink of liquor?
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. more than once a year but less than once a month
   5. once a year or less

   _____

6. When you drink liquor how many drinks, on the average, do you usually drink at any one time?
   1. over 6 drinks
   2. 5 or 6 drinks
   3. 3 or 4 drinks
   4. 1 or 2 drinks
   5. less than 1 drink

   _____

7. We would also like to ask you about marijuana and hash. (If you've never tried marijuana or hash place a "0" in the space provided and skip to question 8.) How often do you **usually** smoke marijuana or hash?
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. at least once a year but less than once a month
   5. once a year or less

   _____

8. We would now like to ask you about cocaine. (If you've never used cocaine, place a "0" in the space provided and skip to question 9.) How often do you **usually** use cocaine?
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. at least once a year but less than once a month
   5. once a year or less

   _____

9. Finally, we would like to ask you about your use of other drugs (psychedelics, ecstasy, amphetamines, tranquilizers, etc.). (If you've never taken other drugs, place a "0" in the space provided and skip to Section C.) How often do you **usually** use other drugs?
   1. every day
   2. at least once a week but not every day
   3. at least once a month but less than once a week
   4. at least once a year but less than once a month
   5. once a year or less

   _____

10. The following is a list of reasons why people drink or take drugs. Do you drink or take drugs for any of the following reasons?
Mark a "3" if you do so frequently.
Mark a "2" if you do so sometimes.
Mark a "1" if you do so rarely.
Mark a "0" if you do not do so.

_____ 1. To forget worries
_____ 2. When under pressure
_____ 3. When feeling lonely
_____ 4. Nothing else to do
_____ 5. Because it's the polite thing to do in certain situations
_____ 6. To cheer up when in a bad mood

C. We Would Now Like to Ask You a Few Questions about Alcohol Use on Campus

1. As a whole, the people I am acquainted with use alcohol:
   1. to a great degree (e.g., several times a week, five or more drinks per time)
   2. to a moderately great degree (e.g., once or twice a week, three or four drinks per time)
   3. to a moderate degree (e.g., two or three times per month, one to three drinks per time)
   4. to a modest degree (e.g., once a month, one or two drinks per time)
   5. Not at all, or almost not at all _____

2. As a whole, my closest friends on campus use alcohol:
   1. to a great degree (e.g., several times a week, five or more drinks per time)
   2. to a moderately great degree (e.g., once or twice a week, three or four drinks per time)
   3. to a moderate degree (e.g., two or three times per month, one to three drinks per time)
   4. to a modest degree (e.g., once a month, one or two drinks per time)
   5. Not at all, or almost not at all _____

3. If you got very drunk one night while out with your closest friends on campus, they would probably:
   1. think it was real cool or funny
   2. think it was fairly cool or funny
   3. not react too strongly one way or another
   4. be a little disapproving or irritated
   5. be strongly disapproving or irritated _____

4. How strong do you feel the emphasis is with respect to drinking at social get-togethers and parties at the University?
   1. very strong (frequently heavy drinking is necessary to get by socially)
   2. moderately strong (you feel obligated to drink, sometimes heavily)
   3. not too strong, but it does exist (people expect you to drink, but you don't have to)
   4. quite mild or non-existent (many people don't drink) _____

5. If you wished to obtain drugs other than alcohol (e.g., marijuana) on campus, or in dorms, fraternities or sororities, how difficult would it be:
   1. very easy
   2. fairly easy
   3. somewhat difficult, but it can be done
   4. quite difficult
   5. don't know _____

6. (Students only). If you got together with freinds to drink on campus, in dorms, fraternities or sororities, how difficult would it be to go about getting something to drink (beer, wine, etc.)?
   1. very easy
   2. fairly easy
   3. somewhat difficult, but it can be done
   4. quite difficult
   5. don't know _____

D. The following are common **results of drinking** that people like yourself have reported. (If you have never had a drink at all go to Section E.) If you currently drink or have drunk in the past, put the number corresponding to the **frequency** of the occurrence in the space beside it.
   1. at least once during the past two months and at least one additional time during the past year.
   2. at least once within the past two months but not during the rest of this past year.
   3. not during the past two months but at least once during the past year.
   4. has happened at least once in my life but not during the past year.
   5. has not happened to me.

_____ 1. have had a hangover
_____ 2. gotten nauseated and vomited from drinking
_____ 3. driven a car after having several drinks
_____ 4. driven a car when you know you have had too much to drink
_____ 5. drinking while driving a car
_____ 6. arrested for DWI (Driving While Intoxicated)
_____ 7. have come to class or work because of a hangover
_____ 8. missed a class or work after having several drinks
_____ 9. been criticized by someone you were seeing or your spouse because of your drinking
_____ 10. had trouble with the law because of drinking
_____ 11. lost a job because of drinking
_____ 12. gotten into trouble with the University administration because of behavior resulting from drinking too much
_____ 13. gotten into a fight after drinking
_____ 14. throught you might have a problem with your drinking
_____ 15. damaged property, pulled a false fire alarm, or other such behavior after drinking

_____ 16. were sexually active when you might otherwise not have been
_____ 17. engaged in unprotected intercourse you might otherwise not have

E. The following are common **results of using drugs** (other than alcohol) that people like yourself have reported. (If you've ever used prescription or non-prescription drugs for recreational purposes, put the number corresponding to the **frequency** of the occurrences in the space beside it. (Others skip to Section G.)

1. at least once during the past two months and at least one additional time during the past year.
2. at least once within the past two months but not during the rest of this past year.
3. not during the past two months but at least once during the past year.
4. has happened at least once in my life but not during the past year.
5. has not happened to me.

_____ 1. been criticized by someone you were seeing or your spouse because of your drug use
_____ 2. driven a car after using drugs
_____ 3. taken drugs while driving a car
_____ 4. arrested for driving under the influence of drugs
_____ 5. have come to class or work after taking drugs
_____ 6. missed a class or work because of a drug hangover
_____ 7. had trouble with the law because of drugs
_____ 8. lost a job because of drugs
_____ 9. gotten into a fight after taking drugs
_____ 10. gotten into trouble with the Brown administration resulting from taking drugs
_____ 11. thought you might have a problem with your drug use
_____ 12. damaged property, pulled a false fire alarm, or other such behavior after using drugs

F. **We Would Like to Ask You Some Information about Alcohol**

The questions will either be TRUE or FALSE. If you do not know the answer to the question, DO NOT GUESS. Mark a "0" in the space provided.
If you think the answer is TRUE, write "1" for true.
If you think the answer is FALSE, write "2" for false.
If you do not know the answer write "0" in the space provided.

_____ 1. Alcohol is usually classified as a stimulant.
_____ 2. Approximately 10% of fatal highway accidents are alcohol related.
_____ 3. A blood alcohol concentration of 0.1% is the legal definition of alcohol intoxication in most states in regards to driving.
_____ 4. It is estimated that approximately 85% of the adult Americans who drink misuse or abuse alcoholic beverages.
_____ 5. Liquor taken straight will affect you faster than liquor mixed with water.
_____ 6. The most commonly drunk alcoholic beverage in the United States is distilled liquor (whiskey, gin, vodka).

_____ 7. Eating while drinking will have no effect on slowing down the absorption of alcohol in the body.

_____ 8. It takes about as many hours as the number of beers drunk to completely burn up the alcohol ingested.

_____ 9. Proof on a bottle of liquor represents half the percent of alcohol contained in the bottle.

_____ 10. Drinking coffee or taking a cold shower can be an effective way of sobering up.

G. We Would Now Like to Ask You about Alcohol-Related Services at the University

1. If you had a problem with alcohol or drugs, would you know precisely where at the University to go for help?
   1. yes, I am well aware of the availability of existing services and programs
   2. yes, I have a general knowledge of existing programs and services
   3. yes, I have some idea of where to go at least to start looking
   4. no, I really don't know where existing programs and services are located _____

2. If you wished to find out more about alcohol and drug use and abuse, would you know just where to go on campus for information?
   1. yes, I am well aware of the availability of existing services and programs
   2. yes, I have a general knowledge of existing programs and services
   3. yes, I have some idea of where to go at least to start looking
   4. no, I really don't know where existing programs and services are located _____

3. As far as you know, does the University have a special program (or programs) designed to inform people about alcohol and drug use and abuse?
   1. yes, a very extensive one
   2. yes, a moderately extensive one
   3. yes, but it's not very extensive
   4. yes, but it is quite limited
   5. not that I'm aware of _____

4. If you've ever used any of the alcohol or drug treatment services on campus, would you say as a whole you were: (Mark "0" if you've never used any services.)
   1. very pleased with the quality of treatment services
   2. somewhat pleased with the quality of treatment services
   3. not particularly pleased with the quality of treatment services
   4. very displeased with the quality of treatment services _____

5. (Students Only) Has the subject of alcohol and/or drug use and abuse ever been raised as part of formal instruction by an instructor in any of the courses you've taken on campus?
   1. yes, in a number of classes
   2. yes, in a couple of classes
   3. yes, but only in one class
   4. no, it was never specifically dealt with (skip to question 7) _____

6. (Students Only) Overall, what do you think of the alcohol and drug use/abuse education you've received in class at the University?
   1. excellent
   2. very good
   3. fair
   4. not particularly good
   5. poor _____

7. Have you ever received any information (outside class) specifically about alcohol and drug use or abuse while at the University?
   1. yes, a number of times
   2. yes, a couple of times
   3. yes, but only once
   4. no, I have never received information specifically about the subject (skip to Section H) _____

8. Overall, what do you think of the information you have received (outside class)?
   1. excellent
   2. very good
   3. fair
   4. not particularly good
   5. poor _____

H. Lastly, We Would Like to Ask You a Few More Questions about Yourself

1. Would you say that your life during the past year has been:
   1. Happy
   2. Moderately happy with ups and downs
   3. Frequently unhappy but with some up periods
   4. Unhappy with frequent upsets _____

2. What is your ethnicity?
   1. White/Caucasian 2. Black/Afro-American 3. Hispanic/Latino
   4. Asian American 5. Foreign Student 6. Other _____ (write in) _____

3. What religion were you brought up in?
   1. Roman Catholic
   2. Protestant (religion allows drinking of alcoholic beverages)
   3. Protestant (religion does not allow drinking)
   4. Jewish
   5. None
   6. Other _____ (write in) _____

4. How important is religion to me:
   1. Very important 2. Moderately important
   3. Mildly important 4. Not important _____

Students Only (Others Skip to End)

5. What is your student status?
   1. Full-time student
   2. Part-time student
   3. Resuming undergraduate education (RUE) _____

6. What were your scores on the SAT? 1. English _____
   2. Mathematics _____

Thank you again for your assistance with our project and for returning the questionnaire by April 10 to: Dr. Steven Ungerleider, Integrated Research Services, Inc., 66 Club Road, Suite 370, Eugene, Oregon 97401.

APPENDIX D: STUDENT REFERRAL FORM

Newberg High School Impact

Student Referral to Core Team

It is necessary for you to take a look at your students and be a relator of actual, OBSERVABLE BEHAVIOR to a Core Team member. If a student exhibits four or five of the following, it may indicate a problem and the need for a referral. If a troubled student is going to be helped, it is necessary for a faculty member to communicate any of the observable behaviors listed below. Due process necessitates that this information, if requested, will be made available to the student or parent. Please place it in an envelope, marked confidential, and return to the Core Team box.

Student _____ Date _____

Grade _____ Person Referring _____ Period _____

Check appropriate responses:

A. Grades
- ___ Lower grades-lower achievement
- ___ Academic failure
- ___ Falls behind in classwork
- ___ Lack of motivation, apathy

B. School Attendance
- ___ Absenteeism
- ___ Tardiness
- ___ On absence list, but in school
- ___ Suspension
- ___ Frequent schedule changes
- ___ Frequent nurse/counselor visits

C. Extra Curricular Activities
- ___ Loss of eligibility
- ___ Decreasing involvement
- ___ Dropped out

D. Physical Symptoms
- ___ Staggering or stumbling
- ___ Smelling of alcohol or pot
- ___ Vomiting

E. Behavior: Criminal/Legal
- ___ Selling drugs, exchanges of money
- ___ Possession of drugs/paraphernalia
- ___ Involvement in thefts/assaults
- ___ Vandalism
- ___ Carrying weapons
- ___ Smoking

F. Behavior: Disruptive Behavior
- ___ Defiance of rules, constant discipline problem
- ___ Cheating
- ___ Irresponsibility, blaming, denying
- ___ Verbal/physical abuse to others
- ___ Throwing objects
- ___ Obscene language, gestures
- ___ Dramatic attention-getting
- ___ Crying
- ___ Constantly in the wrong area
- ___ Extreme negativism
- ___ Hyperactivity, nervousness

From Leatt (1987).

APPENDIX E: HOW TO DEVELOP A DRUG POLICY

- Different approaches to policy development;
- How committees should proceed;
- Topics to be covered.

Who develops drug policies?

Historically, principals and administrators have, but that is changing. Significant participation of the community is now considered critically important, as pointed out in the previous section.

They are better developed at the district or county level to guarantee consistency and avoid duplication.

Several approaches can be followed:

- Policies are drafted by administrators and submitted to a citizen task force for review.
- A committee develops the policies for submission to administrators to implement.
- The committee develops policies and procedures that are binding on administrators.
- The school board creates a committee which draws up policies to be approved by the board.
- Perhaps the most acceptable method is to have the community committee develop the policies and the school board assign the task of drawing up procedures to the staff for review by the board. The growing practice is to establish a committee, chaired by an administrator, a community leader or even a board member, to take some part in the policy development process. Members should include board members, administrators, teachers, a district or county drug specialist, a counselor or psychologist, PTA representatives, parents, student government members, other students, law enforcement officers, community drug abuse program people, local government officials, religious leaders, service club members, community organization representatives, business leaders and legal counsel.

Early in the process, the committee should:

√ Define the role and authority of the committee;
√ Determine the function of school drug policies;
√ Compile the laws and regulations affecting drug policies;

From McCurdy, et al. (1986).

- √ Clarify school-community views of its responsibility in dealing with drug use;
- √ Determine the need for revising policies;
- √ Examine existing policies, if any;
- √ Determine process to be used in developing new policies and making recommendations;
- √ Establish timelines for completing its work.

Creation of subcommittees have been found to be very useful in focusing efforts on key areas:

- Discipline—to study existing laws, court decisions and local regulations on drug use;
- Prevention—to review research on substance abuse and develop criteria to assess programs;
- Intervention—determine policies for dealing with instances of drug use or "at-risk" students;
- Emergencies—to develop policies for managing drug-related emergencies at school;
- Other drugs—to develop policies covering prescription, over the counter and other legal drugs.

Guidelines for Developing Drug Policies

Policies should:

- √ Be clear and unambiguous;
- √ Be legally sound and consistent with the rights of all students to a school environment conducive to learning;
- √ Be consistently applied without exception;
- √ Be well publicized;
- √ Provide for drug education that is based on accurate and scientifically valid information;
- √ Require that alcohol and drug education curricula be used on all grade levels;
- √ Be unequivocal in requiring a no-use, drug-free school and school-related environment;
- √ Should recognize that parents ultimately assume the primary responsibility for their children's drug use but not allow differences in parental standards to compromise the school's legal and moral commitment to establish and maintain a drug-free environment.

—The American Council for Drug Education

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RESOURCES

IMPACT Training/Information

National Training Associates
P.O. Box 1270
Sebastopol, CA 95473
800-624-1120

Western Center for Drug-Free Schools and Communities
101 S.W. Main Street
Suite 500
Portland, OR 97204

Mary Simpson, Counselor
Newburg High School
Elliot Road
Newburg, OR
(503) 538-8361

General Information

The National Federation of Parents for Drug-Free Youth (NFP)
800-554-KIDS

Parents' Resource Institute for Drug Education (PRIDE)
800-241-9746

Division of Substance Abuse Services
800-522-5353

National Clearinghouse for Drug Abuse Information
800-638-2045 (National)
800-492-2948 (Maryland)

Cocaine Hotlines:

Fair Oaks Hospital
Summit, NJ
800-COCAINE

National Institute on Drug Abuse (NIDA)
5600 Fishers Lane
Rockville, MD 20857
800-662-HELP

Parent Programs/Activities

Mothers Against Drunk Driving (MADD)
669 Airport Freeway, suite 310
Hurst, TX
(817) 268-MADD

Parents' Resource Institute for Drug Education (PRIDE)
100 Edgewood Avenue, suite 1216
Atlanta, GA 30303
800-241-7946
(404) 658-2548

National Federation of Parents for Drug-Free Youth
8730 Georgia Avenue, Suite 200
Silver Springs, MD 20910
(301) 585-KIDS

The National PTA
700 North Rush Street
Chicago, IL 60611

Student Groups

Students Against Driving Drunk (SADD)
66 Diana Drive
Marlboro, MA 01752
(617) 481-3568

Assessing Drug Abuse Problems

Chemical Dependency Adolescent Assessment Project
Amherst H. Wilder Foundation
1295 Bandana Boulevard North, Suite 210
St. Paul, MN 55108

Training Programs

"Reach America" Student Training Seminars
National Federation of Parents
1820 Franwall Avenue, Suite 16
Silver Spring, MD 20902
800-544-KIDS
(301) 649-7100

The School-Community Action Team Model
MADART Project Director
Maryland Department of Education
200 West Baltimore Street
Baltimore, MD, 21201
(301) 659-2321

For specific descriptive and funding information about the School Team Approach, write or call the nearest regional training center or

Office of Alcohol and Drug Abuse Education
U.S. Department of Education
400 Maryland Avenue, SW, Room 2011
Mail Stop 6264, Building FOB-6
Washington, DC 20202
(202) 755-0410

Northeast

U.S. Department of Education
Alcohol and Drug Abuse Training and Resource Center
Adelphi National Training Institute
P.O. Box 403
Sayville, NY 11782-0403
(516) 589-7022

Southeast

U.S. Department of Education
Alcohol and Drug Abuse Training and Resource Center
5915 Ponce DeLeon Boulevard, Suite 11
Coral Gables, FL 33146
(305) 284-5741

Southwest

U.S. Department of Education
Alcohol and Drug Abuse Training and Resource Center
Center for Educational Development
6800 Park Ten Boulevard, Suite 171 West
San Antonio, TX 78213
(512) 735-9191

West

U.S. Department of Education
Alcohol and Drug Abuse Training and Resource Center
Region 8 Training and Development Center, Inc.
Box 9997 Mills College Station
Oakland, CA 94163
(415) 632-3775

Midwest

U.S. Department of Education
Alcohol and Drug Abuse Training and Resource Center
2 North Riverside Plaza, Suite 821
Chicago, IL 60606-2653
(312) 726-2485

Training Materials and Workshops

American Training Center, Inc.
P.O. Box 3140
Boulder, CO 80307
(303) 442-5010

Capabilities, Inc.
P.O. Box 318
Lexington, SC 29072

Community Intervention, Inc.
529 South 7th Street, Suite 570
Minneapolis, MN 55415
800-328-0417

Johnson Institute
10700 Olson Memorial Highway
Minneapolis, MN 55441
(612) 544-4165

PRIDE Inc.
100 Edgewood Avenue, Suite 1216
Atlanta, GA 30303
800-241-7946
(24-hour hotline and tapes on drug and alcohol abuse)

School Policies

Copies of school system policies on drug and alcohol abuse, and recommendations of schools with good policies.

The National Institute on Drug Abuse (NIDA)
5600 Fishers Lane
Rockville, MD 20857

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
(703) 838-6722

Public Affairs Staff
Drug Enforcement Administration
14th and I Streets N.W.
Washington, D.C., 20537

Additional Organizations to Contact for Help, Information, and Materials

Alateen, Al-Anon Family Group Headquarters, Inc.
P.O. Box 182
Madison Square Station
New York, NY 10159
(212) 481-6565

Alcoholics Anonymous
General Service Office
P.O. Box 459
Grand Central Station
New York, NY 10163
(212) 686-1100

American Automobile Association (AAA)
Traffic Safety Department
Falls Church, VA 22047
(703) 222-5000

American Cancer Society
777 Third Avenue
New York, NY 10017
(212) 371-2900

American Council for Drug Education
5820 Hubbard Drive
Rockville, MD 20852
(301) 984-5700

American Lung Association
1740 Broadway
New York, NY 10019
(212) 245-8000

National Association for Children of Alcoholics
31706 Coast Highway, Suite 201
South Laguna, CA 92677

National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852

National Clearinghouse for Drug Abuse Information
P.O. Box 416
Kensington, MD 20795
800-638-2045 (National)
800-492-2948 (Maryland)

National Council on Alcoholism
733 Third Avenue
New York, NY 10017

National Federation of Parents for Drug-Free Youth
1820 Franwall Avenue
Silver Spring, MD 20902
(301) 649-7100

National Highway Traffic Safety Administration
Office of Alcohol Countermeasures
NTS 21
400 Seventh Street, SW
Washington, DC 20590

National Institute on Drug Abuse (NIDA)
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6245

National School Safety Center
7311 Greenhaven Drive
Sacramento, CA 95831
(916) 427-4600

Parents' Resource Institute for Drug Education (PRIDE)
100 Edgewood Avenue, Suite 1216
Atlanta, GA 30303
800-241-7946
(404) 658-2548

Center for Community Change
100 Wisconsin Avenue, NW
Washington, DC 20007

Center for Multi-Cultural Awareness (CMA)
2924 Columbia Pike
Arlington, VA 22204

U.S. Department of Education
Black Concerns Staff
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

National Black Alcoholism Council (NBAC)
United Methodist Building
100 Maryland Avenue, NE
Washington, DC 20002

National Center for Alcohol Education (NCAE)
1601 North Kent Street
Arlington, VA 22209

National Council on Alcoholism (NCA)
Minority Program
733 Third Avenue
New York, NY 10017

National Parent Teacher Association (PTA)
Alcohol Education Project
700 North Rush Street
Chicago, IL 60611

National Youth Work Alliance (NYWA)
1346 Connecticut Avenue, NW
Washington, DC 20036

Pyramid Project
7101 Wisconsin Avenue, Suite 1006
Bethesda, MD 20014

EJ360561 CG532907
Psychopathology as an Antecedent to, and as a "Consequence" of, Substance Use, in Adolescence.
Friedman, Alfred S.; And Others
Journal of Drug Education, v17 n3 p233-44 1987
Conducted longitudinal study of 232 high school students and found that earlier psychopathology predicted, to a statistically significant degree, substance use 17 months later, and that earlier substance use predicted later psychopathology. Among nine types of psychic symptoms measured, obsessive-compulsive symptoms, hostility, paranoid ideation, and depression were most predictive of later substance use. (Author/NB)

EJ360554 CG532900
An Aftercare Group Model for Adolescent Substance Abusers.
Coleman, Sally
Journal of Alcohol and Drug Education, v32 n3 p53-59 Spr 1987
Available from: UMI
Discusses what makes an aftercare group for adolescent substance abusers function productively and describes the format that seems to work best for young adolescents in an aftercare group. Emphasizes importance of group facilitator skills in areas of leadership, safety, and structure in helping adolescents gain re-identification as abstaining members of society and commitment to recovery from addiction. (NB)

EJ360550 CG532896
Alcoholism and Personal Responsibility: A Philosopher Dissents.
Walker, David E.
Journal of Alcohol and Drug Education, v32 n3 p38-41 Spr 1987
Available from: UMI
Asserts that a primary concern to the alcoholic and to those who try to help him is the behavior that causes alcohol dependency. While not disputing the view that alcoholism may be a disease, argues that full responsibility should be assigned to the alcoholic for his behavior. (NB)

EJ360548 CG532894
Rethinking Critical Issues in Drug Programming.
Werch, Chudley E.
Journal of Alcohol and Drug Education, v32 n3 p19-24 Spr 1987
Available from: UMI
Asserts that few critical issues in drug programming are being thoughtfully considered. Suggests that health educators and other professionals involved in drug program development must seriously consider program problems of goal selection, policy development, student rights and protection, clarification of drug-related terminology, and evaluation processes. (Author/NB)

EJ360545 CG532891
Undergraduate Alcohol Misuse: Suggested Strategies for Prevention and Early Detection.
Cherry, Andrew
Journal of Alcohol and Drug Education, v32 n3 p1-6 Spr 1987
Available from: UMI
Surveyed 121 undergraduates on their alcohol use. Respondents indicated that if they were having an alcohol or drug problem, they would turn to a friend for help. Students who belonged to

two or more college organizations were found to have light to moderate drinking patterns. Suggests strategies for deterring misuse of alcohol. (Author/NB)

EJ360513 CG532859
Parameters of Teenage Alcohol Use: A Path Analytic Conceptual Model.
Kline, Rex B.; And Others
Journal of Consulting and Clinical Psychology, v55 n4 p521-28 Aug 1987
Available from: UMI
Surveyed high school students (N=499) to evaluate theoretical model of teenage drinking with latent-variable path analysis. Results suggest many intricate direct and indirect relations among several classes of variables that powerfully predicted teenage drinking. Discusses implications of findings for future research and for treatment and prevention of teenage alcohol abuse. (Author/NB)

EJ358301 IR517214
Alcohol Research Information: A Guide to Resources.
Page, Penny Booth
Behavioral & Social Sciences Librarian, v6 n1-2 p1-14 Fall-Win 1986
Target Audience: Media Staff; Practitioners
Provides guidelines for locating alcohol research information and building library collections on alcohol. Resource organizations, including government agencies, research institutions, and publishers, are identified and several access tools are described. The future directions of alcohol research and its dissemination are discussed. (Author/EM)

EJ357857 CG532551
Outcomes of Treatment for Alcohol Problems: Current Methods, Problems, and Results.
Nathan, Peter E.; Skinstad, Anne-Helene
Journal of Consulting and Clinical Psychology, v55 n3 p332-40 Jun 1987
Available from: UMI
Discusses current methods, problems, and results of psychological treatment for alcohol abuse, including alcoholism. Addresses external and internal validity problems specific to issues regarding who is treated for alcohol problems, and treatment and patient factors that predict response to alcoholism treatment. Reviews current data on nonproblem-drinking treatment goals. (Author/KS)

EJ357856 CG532550
Cognitive Studies in Alcoholism.
Wilson, G. Terence
Journal of Consulting and Clinical Psychology, v55 n3 p325-31 Jun 1987
Available from: UMI
Commends cognitive studies for extending our understanding of alcohol use and abuse. The role of vicarious learning and efficacy and outcome expectations in the development, maintenance, and prevention of drinking, is stressed. Reinterpreted concepts of craving and loss of control as well as models of relapse and prevention treatment strategies, increasingly reflected the influence of cognitive-social learning theory. (Author/KS)

EJ357854 CG532548
Biological Vulnerability to Alcoholism.
Schuckit, Marc A.
Journal of Consulting and Clinical Psychology, v55 n3 p301-09 Jun 1987
Available from: UMI
Reviews the role of biological factors in the risk for alcoholism. Notes the importance of the definition of primary alcoholism and highlights data indicating that this disorder is genetically influenced. In studies of men at high risk for the future development of alcoholism, vulnerability shows up in reactions to ethanol brain wave amplitude and cortical electroencephalograms. (Author/KS)

EJ357852 CG532546
Epidemiology of Alcoholism.
Helzer, John E.
Journal of Consulting and Clinical Psychology, v55 n3 p284-92 Jun 1987
Available from: UMI
Reviews the application of epidemiology to alcoholism. Discusses measurement and diagnostic issues and reviews studies of the prevalence of alcoholism, its risk factors, and the contributions of epidemiology to our knowledge of treatment and prevention. (Author/KS)

EJ357837 CG532531
The Theoretical Model: Diagnostic Assessment and Placement in Prevention Treatment Mode by School Personnel.
Sullivan, Arthur P.; And Others
Journal of Drug Education, v17 n1 p59-67 1987
Presents as a formal model the process by which New York City Public School children are identified and provided with substance abuse prevention education or intervention services. The aligning of the students with specific services is like a psychological diagnostic-prescriptive process. Displays schematically the decision model, differential diagnoses, prevention dynamics, and the match of student-to-service. (Author/KS)

EJ357715 CG532408
The "No-Problem Problem": A Family Therapy Approach for Certain First-Time Adolescent Substance Abusers.
Eastwood, Matthew; And Others
Family Relations, v36 n2 p125-28 Apr 1987
Available from: UMI
Presents a family therapy model for working with "no problem problem" families of first offense adolescent substance abusers. Illustrates applications of this model through a case example. Describes the model as a practical therapy approach that is present- and future-oriented and seeks to build on family strengths. (Author/ABB)

EJ355264 CG532134
A Psychoeducational Group for Adult Children of Alcoholics.
Downing, Nancy E.; Walker, Margaret E.

Journal of Counseling & Development, v65 n8 p440-42 Apr 1987
Available from: UMI
Describes a campus-based psychoeducational support group for adult children of alcoholics. Outlines group goals; identifies recruitment procedures; and describes and evaluates sessions. Asserts that this successful group format could be easily adapted to other setting and age groups. (Author/ABB)

EJ353630 CG532060
Relapse Prevention with Substance Abusers: Clinical Issues and Myths.
Daley, Dennis C.
Social Work, v32 n2 p138-42 Mar-Apr 1987
Available from: UMI
Discusses the problems of relapse with alcoholics and other drug abusers from three perspectives: client-related variables, common erroneous beliefs and myths held by professionals regarding relapse, and treatment system problems that may contribute to relapse. Offers proposed solutions and describes a relapse prevention model. (Author/ABB)

EJ353617 CG532047
Social Bond Theory and Alcohol Use Among College Students.
Cherry, Andrew L., Jr.
Journal of College Student Personnel, v28 n2 p128-35 Mar 1987
Available from: UMI
Investigated incidence of alcohol use by college students, relationship among social bond variables, and ability of social bond variables to predict alcohol use. Psychosocial scales measuring elements of social bond to the college community were used successfully to classify abstainers, light-to-moderate drinkers, and heavy drinkers in 74% of the cases. (Author/ABB)

EJ352982 SE540480
Prevention Strategies for Drug Abuse.
Goodstadt, Michael S.
Issues in Science and Technology, v3 n2 p28-35 Win 1987
Target Audience: Practitioners
Addresses the problems associated with the effectiveness of drug prevention strategies. Argues that prevention programs must be tailored to the characteristics of the user, the drug, and the use. Comments on why school-based programs have had little or no impact. (ML)

EJ352325 EA521212
Schoolchildren and Drugs: The Fancy That Has Not Passed. Kappan Special Report.
Hawley, Richard A.
Phi Delta Kappan, v68 n9 pK1-K8 May 1987
Available from: UMI
Target Audience: Practitioners; Policymakers
Explores the destructive effects of student drug use on students, teachers, and the learning environment of public schools. Discusses healthy child development and the historical background of illegal drug use, and suggests strategies to produce a drug- and alcohol-free school environment with firm, clear institutional policies. (MLH)

EJ351926 CE517949
Alcohol, Tobacco and Marijuana Use among Youth: An Overview of Epidemiological, Program and Policy Trends.
Wallack, Lawrence; Corbett, Kitty
Health Education Quarterly, v14 n2 p223-49 Sum 1987
Available from: UMI
Reviews trends in the use of alcohol, tobacco, and marijuana among high school seniors. Previous and current prevention efforts are highlighted and promising prevention approaches identified. (CH)

EJ351351 PS514936
Children's Books About Alcoholism.
Fassler, David G.
Childhood Education, v63 n3 p188-94 Feb 1987
Available from: UMI
Attempts to identify and evaluate reading material currently available to introduce young children to the topics of alcohol and alcoholism. (BB)

EJ350478 CG531757
A Counseling Approach to Alcohol Education in Middle Schools.
Ostrower, Emily Garfield
School Counselor, v34 n3 p209-18 Jan 1987
Available from: UMI
Presents a curriculum and program specifically for middle school students (Grades 6-8) that focuses on alcohol and the personal problems associated with alcoholism. Includes a decision-making component and encouragements to seek help. (Author/ABB)

EJ350437 CG531716
Drug Abusers and Card 3BM of the TAT.
Patalano, Frank
Psychology: A Quarterly Journal of Human Behavior, v23 n2-3 p34-36 1986
Available from: UMI
Card 3BM of the Thematic Apperception Tests is valuable in assessing people with drug problems. Drug abusers often apperceive the lone figure in the picture as an addict, the revolver as a hyperdermic needle. Overdose situation themes are prevalent. Data concerning the individual's drug problems, attitudes, self-destructive tendencies, coping mechanisms, and supportive resources are often revealed. (Author/KS)

EJ350421 CG531700
Can School-Based Educational Programs Really Be Expected to Solve the Adolescent Drug Abuse Problem?
Lohrmann, David K.; Fors, Stuart W.
Journal of Drug Education, v16 n4 p327-39 1986
Reviews 1984 Rand Corporation report recommendation that preventive education is most effective way to prevent adolescent drug abuse within the context of theories related to the causes of drug abuse integrated with the PRECEDE model of health education program planning. Concludes that many variables influencing adolescent drug use are not within the purview of schools. (Author/NB)

EJ347129 EA520793
Seeking Peace in the War on Drugs.
Sagor, Richard
NASSP Bulletin, v71 n495 p84-87 Jan 1987
Available from: UMI
The rate of teenage drug abuse is at one of its lowest points in 25 years. The current "war on drugs" has overlooked a set of distinctions in its policy and in the discussions occurring in the schools. Presents the distinctions between use, abuse, and dependence. (MD)

EJ346527 UD512571
Future Issues and Promising Directions in the Prevention of Substance Abuse Among Youth.
Kumpfer, Karol L.; And Others
Journal of Children in Contemporary Society, v18 n1-2 p249-78 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Provides a scheme for conceptualizing the various approaches to prevention in relation to the Public Health Services prevention model, the Host/Agent/Environment Triad. Discusses areas of research necessary before prevention approaches can be prioritized. Speculates about the future of prevention and recommends the most promising approaches. (Author/LHW)

EJ346526 UD512570
Treatment for Childhood Chemical Abuse.
Beschner, George
Journal of Children in Contemporary Society, v18 n1-2 p231-48 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Describes intervention and treatment services available to youth and adolescents with chemical abuse problems. Discusses necessary components of a comprehensive approach. Reviews research on treatment outcomes within the various types of programs along with research on the treatment models employed. (Author/LHW)

EJ346525 UD512569
The Multicultural Model in Chemical Abuse Prevention and Intervention.
Griswold-Ezekoye, Stephanie
Journal of Children in Contemporary Society, v18 n1-2 p203-29 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Applies the concept of multiculturalism to chemical abuse prevention and intervention programs. Provides a model for implementation and describes projects with a similar conceptual basis. Acknowledges the cultural foundations for developing positive self-understanding. Promotes the development of culture-specific prevention strategies. (Author/LHW)

EJ346524 UD512568
Comprehensive Community Programs for Drug Abuse Prevention.
Johnson, C. Anderson; And Others
Journal of Children in Contemporary Society, v18 n1-2 p181-99 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Describes both a pilot and a larger research effort to implement and evaluate a comprehensive community-based approach to drug abuse prevention. Outlines criteria for success, involving school, media, parent, and community organization programs. (Author/LHW)

EJ346521 UD512565
School-Based Substance Abuse Prevention: A Review of Program Research.
Bukowski, William J.
Journal of Children in Contemporary Society, v18 n1-2 p95-115 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Classifies school-based prevention activities into the following five educational domains: (1) cognitive; (2) affective/interpersonal; (3) behavioral; (4) environmental; and (5) therapeutic. Discusses research findings for each domain. (Author/LHW)

EJ346519 UD512563
Childhood Predictors of Adolescent Substance Abuse: Toward an Empirically Grounded Theory.
Hawkins, J. David; And Others
Journal of Children in Contemporary Society, v18 n1-2 p11-48 Fall-Win 1985
Special Issue: Childhood and Chemical Abuse: Prevention and Intervention.
Reviews the etiology of chemical use and abuse among children and adolescents. Discusses progression of youth drug behavior from initial to occasional and/or regular use. Identifies the following predictors of chemical abuse: (1) antisocial behavior; (2) school acquiescence; (3) peer influence; and (4) age at onset of use. (Author/LHW)

EJ346383 SP516407
The Efficacy of Peer Leaders in Drug Abuse Prevention.
Klepp, Knut-Inge; And Others
Journal of School Health, v56 n9 p407-11 Nov 1986
Available from: UMI
A theoretical rationale for using peer leaders as a major strategy in school-based drug abuse prevention programs is provided. Available literature on such programs is reviewed. Practical issues involved in selecting and training peer leaders and teachers are discussed. (Author/MT)

EJ345800 HE521754
Maryland Panel Proposes Anti-Drug-Abuse Plan, Urges Campus to Be a Model for Other Universities.
Hirschorn, Michael
Chronicle of Higher Education, v33 n17 p33 Jan 7 1987
A University of Maryland panel on drug abuse hopes its report on drug policies, enforcement, and education will become a prototype for other colleges and universities. It uses four approaches to combat substance abuse: education and counseling, discipline, drug testing, and law enforcement. (MSE)

EJ343529 CG531123
Observations on Substance Abuse Theory.
Shaffer, Howard J.
Journal of Counseling & Development, v65 n1 p26-28 Sep 1986
Available from: UMI
Applies a philosophy of science perspective to substance abuse theory to clarify these theories in general and peer cluster theory in particular. Examines the natural history of an illicit drug from a macroscopic level of analysis to illuminate some of the social-psychological factors that influence drug use and abuse patterns. (Author/KS)

EJ343528 CG531122
The "Cure" for Adolescent Drug Abuse: Worse than the Problem?
Peele, Stanton
Journal of Counseling & Development, v65 n1 p23-24 Sep 1986
Available from: UMI
Analyzes Oetting and Beauvais's article on Peer Cluster Theory and drug use, agreeing with their focus on the role of the individual, the environment, and experience with use of a substance, but disagreeing with the notion of physical dependence. Advocates that society give children the competencies, values, and opportunities to find superior alternatives to drug use. (KS)

EJ341136 EA520321
In the Classroom Stoned.
Shannon, Jessica
Phi Delta Kappan, v68 n1 p60-62 Sep 1986
Available from: UMI
Target Audience: Practitioners
A mother reports on her daughter's former drug abuse, the inability of school officials to recognize and deal effectively with drug abusers, possible reasons for this inability, and recent legal decisions that require districts to provide counseling. She concludes by offering suggestions for dealing with problems of abuse. (IW)

EJ340887 CG530769
Youths' Perceptions of Alcoholism.
Lorch, Barbara (Day); Hughes, Robert H.
Journal of Alcohol and Drug Education, v31 n3 p54-63 Spr 1986
Available from: UMI
Only a third of students in this study accepted the medical model of alcoholism. Those who had the least knowledge of, and experience with, alcohol were the most likely to consider alcoholism as an illness. The source of information on drugs most conducive to acceptance of the medical model was parents. (Author/ABB)

EJ339271 PS514493
Kids and Drugs: Why, When and What Can We Do about It?
Jones, Coryl LaRue; Bell-Bolek, Catherine S.
Children Today, v15 n3 p5-10 May-Jun 1986
Discusses why an individual begins to experiment with drugs and when such activities are likely to take place. An understanding of these factors provides insight into ways to prevent drug abuse. Notes that the family may prove to be the most enduring point of prevention and intervention. (BB)

EJ337235 CG530386
Evaluating Prevention and Intervention Procedures.
Sullivan, Arthur P.; And Others
Journal of Drug Education, v16 n1 p91-98 1986
States the process-outcome research and evaluation paradigm applied to alcohol and substance abuse prevention and intervention programs. Shows its application to efforts to improve students' and patients' self-esteem to be deficient in certain aspects and advocates additions to the evaluation procedures, most notably analysis of in-session change. (Author/ABB)

EJ337234 CG530385

"SPECDA"-A Comprehensive Approach to the Delivery of Substance Abuse Prevention Services in the New York City School Systems.

Blotner, Roberta; Lilly, Levander

Journal of Drug Education, v16 n1 p83-89 1986

Evaluates SPECDA (School Program to Educate and Control Drug Abuse) a comprehensive substance abuse prevention program which links drug counselors and police officers in teams to provide drug education. Results indicated significant positive changes in children's knowledge about drugs, attitudes toward drugs, and attitudes toward polic officers and drug counselors. (Author/ABB)

EJ337176 CG530327

Assessment of the Problem Drinker: A Primer for Counselors.

Packard, Michele A.

Journal of Counseling & Development, v64 n8 p519-22 Apr 1986

Available from: UMI

Target Audience: Counselors; Practitioners

People with drinking problems are overrepresented in counseling settings. Counselors have been unable to identify accurately the problem drinker, resulting in a decrease in counselor effectiveness. Describes seven variables that help identify problem drinking and two variables that help diagnose alcoholism. Suggestions for conducting the assessment interview are provided. (Author/BL)

EJ332448 TM511114

Alcohol: The Gateway to Other Drug Use Among Secondary-School Students.

Welte, John W.; Barnes, Grace M.

Journal of Youth and Adolescence, v14 n6 p487-98 Dec 1985

The "stepping-stone" theory of progression into drug use is examined, based on the alcohol and other drug use of over 27,000 seventh- through eighth-grade students in New York State. The data show that students do not use illicit drugs unless they also use alcohol. (Author/LMO)

EJ329663 EA519564

Frequent Marijuana Use in Adolescence: What Are the Signs, Stages?

Schwartz, Richard H.

NASSP Bulletin, v69 n485 p103-08 Dec 1985

Available from: UMI

Target Audience: Administrators; Practitioners

Frequent use of marijuana has reached an alarming proportion in the student population. Outlines the signs and stages of frequent use so that educators can recognize the symptoms and intervene. (MD)

EJ327696 CG529515

Preparing Parents for Teenagers: A Step in the Prevention of Adolescent Substance Abuse.

Grady, Katherine; And Others

Family Relations, v34 n4 p541-49 Oct 1985

Available from: UMI

Presents an overview of the intervention program and the results of the research project evaluating the effectiveness of the program. Parent participants in the course when compared with delayed treatment control group parents, showed an increased ability to use decision making facilitation skills in responding to typical child statements. (Author/BL)

EJ323285 CG529075
Annotated Bibliography.
Dykhuis, Randy
Journal of Alcohol and Drug Education, v30 n3 p50-64 Spr 1985
Available from: UMI
Target Audience: Media Staff; Practitioners
Lists six sections of resources on alcohol and alcoholism to guide librarians in selecting materials for alcoholic patrons and to show what kinds of education are possible in the public library. Sections include alcohol and alcoholism, alcohol education, fiction, nonprint resources, bibliographies, and other information sources. (BH)

EJ323284 CG529074
Drug Abuse A Real Phenomenon on the College Campus: Appropriate Programs Do Work.
Hamilton, Beatrice H.
Journal of Alcohol and Drug Education, v30 n3 p45-49 Spr 1985
Available from: UMI
Describes treatment methods designed to teach self-help skills to the abusive drinker, i.e., assertiveness training, muscle relaxation, and academic survival groups. A literature review shows a drinking problem among college students. Reasons given for excessive drinking were to relieve anxiety, to feel good, and to enhance sociability. (Author/BH)

ED286121 CG020204
Alcoholism as a Discrete Personality Variable: Implications for its Heritability and Treatment.
Dana, Dudley; Walsh, James A.
1 May 1987
17p.
EDRS Price - MF01/PC01 Plus Postage.
Gangestad and Snyder (1985) have proposed two types of personality variables: continuous variables (characteristics possessed to some degree by all individuals) and class variables (characteristics distributed into discrete classes). This study examined whether alcoholism could be classified as a class variable. Because a class variable will exhibit a particular pattern among the covariance of its indicators, a pilot study was conducted to identify 10 indicators from the Drinking History Questionnaire, the MacAndrew Scale, the Comprehensive Drinker Profile, the Mortimer Filkens Test, and the Western Personality Inventory. The indicators were given to 125 male alcoholics and to 200 male nonalcoholics. Covariance among the items was plotted by level of response to the indicators. The covariance between each possible item pair was plotted for eight levels of responses to the indicators. The plot of the covariance among items by level of response to the indicators peaked toward the middle, indicative of the existence of a class variable. A high level of agreement between the simplest base rate estimation and the proportion of alcoholics in the sample provided support for the results. These findings suggest that alcoholism has a latent class variable underlying its development. A class variable, with its specific etiology,

is much more likely to be genetic in origin than is a continuous variable, with its diffuse etiology. This finding has implications for the treatment and prevention of alcoholism. (NB)

ED286103 CG020186
The University Chemical Dependency Project: Final Report.
Bloch, Steven A.; Ungerleider, Steven
Integrated Research Services, Eugene, OR.
1 Nov 1986
160p.
Available from: Integrated Research Services, 66 Club Rd., Suite 370, Eugene, OR 97401 (free).
EDRS Price - MF01/PC07 Plus Postage.
To cope with changes in the way that alcohol and drugs are used and abused, college administrations have altered their appproaches to dealing with the problem. This study surveyed 971 students, faculty, and staff members of one university to assess: the level of alcohol and drug use and abuse at the university; factors associated with substance abuse; and the level of awareness and satisfaction with prevention, educational services, and treatment programs available on campus. This final report presents findings from the study. The first two sections of the report describe and analyze the context of the university's substance abuse program. Alcohol and drug use and abuse on U.S. campuses are discussed, approaches designed to alleviate alcohol and drug problems on campus are described, and the components of the university's program are compared to those at other universities. The next section delineates basic research issues to be investigated in the study, presents a general model of alcohol use and abuse, and explores the study methodology. Results are provided in the next section. A discussion and conclusion section assesses and interprets major findings of the study, comparing some of the findings to those obtained in a national study of alcohol use and abuse at colleges in the United States. One figure, 50 tables, and the survey questionnaire are included. (NB)

ED286080 CG020163
Student Assistance Program Sandia High School 1985-86 Report.
Boyce-Prather, Margaret; Shainline, Michael
Albuquerque Public Schools, N. Mex.
Jun 1986
28p.
EDRS Price - MF01/PC02 Plus Postage.
This document presents data from the second year of the Student Assistance Program, a counseling program to help students who may be abusing drugs or alcohol, implemented at Sandia High School in the Albuquerque (New Mexico) Public School system. Data are included from the program's monthly records sheets, from parent involvement questionnaires, and from faculty and student surveys. Data tables and text are organized into seven major sections: Summary of Presentations, Sources of Referrals, Counseling and Outside Referrals, Parent Involvement Program, Faculty Surveys, Student Surveys, and a Conclusion. The conclusion summarizes the report findings that: (1) students were usually referred to the program by school administrators or the school detective but, as the year progressed, referrals from friends and teachers increased; (2) referred students usually received counseling from the program counselors, although some referrals were made to outside treatment facilities; (3) participants in the 8-week Parent Involvement Program for students and parents rated the program organization and quality favorably, but ratings were mixed with regard to how well the program met their individual needs; (4) nearly one-

half of faculty respondents reported having referred students to the program, while all reported a high need for the program at the school; and (5) more than one-half of the students surveyed reported being unaware of the program, but stated they would encourage friends needing help to use the program. Survey forms are appended. (NB)

ED286010 CE048293

Preventing Alcohol and Drug Abuse through Programs at the Workplace. WBGH Worksite Wellness Series.

Walsh, Diana Chapman; Kelleher, Susan E.

Washington Business Group on Health, Washington, DC.

Feb 1987

53p.; For related documents, see CE 048 292-305.

Sponsoring Agency: Public Health Service (DHHS), Rockville, MD. Office of Disease Prevention and Health Promotion.

Available from: Prevention Leadership Forum, Washington Business Group on Health, 229 1/2 Pennsylvania Avenue, SE, Washington, DC 20003 ($15.00).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

Alcohol and drug abuse have serious physical, psychological, and social consequences, and employees who abuse alcohol and/or drugs ultimately reduce their companies' profits. Employee substance abuse leads to reduced productivity as well as to increased absenteeism, health care and health insurance costs, and liability claims against employers of persons who abuse substances. Programs to prevent substance abuse can take one of three forms. Primary prevention programs focus on changes in the environment or anticipatory education to obviate problems that are as yet undiscernible (for example, programs on the hazards of drinking and driving or policies requiring warning labels on liquor bottles). Secondary prevention involves efforts to identify and change established health risks before these risks have done irreversible harm (for example, mandatory educational programs for drivers arrested while intoxicated). Tertiary prevention programs occur at a late stage and are palliative in orientation (that is, they are a form of treatment that is geared toward preventing further harm). Possible types of primary and secondary prevention efforts can include educational and awareness activities, company policies to prevent alcohol and drug abuse (such as drug screening and drug searches), and early problem identification and referral. (Eight examples of companies that have developed successful drug and alcohol abuse prevention programs are included in this document.) (MN)

ED285108 CG020151

Sex-Role Conflict in Female Athletes: A Possible Marker for Alcoholism.

Wetzig, Diane L.

Apr 1987

29p.; Paper presented at the Annual National Symposium on Building Family Strengths (10th, Lincoln, NE, May 13-15, 1987).

EDRS Price - MF01/PC02 Plus Postage.

The impact of sex-role conflict among females has been an issue of concern in both the sports arena and the field of alcoholism. This study explored the similarities in sex-role conflict between female athletes and alcoholic women. Subjects were 30 female inpatients of a chemical dependency treatment center; 30 undergraduate students; and 30 intercollegiate female athletes from university baseball, track, and basketball teams. Subjects completed the Personal Attributes Questionnaire on two consecutive administrations, once describing their "real" behavior and once describing their "ideal" deportment. The results indicated that female athletes and female

alcoholics were similar to each other and different from controls along the dimensions of sex-role conflict. A literature review revealed parallels between female athletes and female alcoholics in the areas of feminine socialization, power needs, competition, and sensation-seeking which also differentiated them from women in general. These findings suggest that female athletes may be more susceptible to alcoholism and chemical dependency than is the average individual. Personnel dedicated to the development of female athletes should be apprised of the many parallels between female athletes and female alcoholics and the danger this resemblance represents. Early and ongoing intervention is recommended. (Author/NB)

ED284323 EA019461

Positive Prevention: Successful Approaches To Preventing Youthful Drug and Alcohol Use and La Prevencion Positiva: Metodos que han tenido exito en la prevencion del uso de drogas y alcohol entre la juventud.

American Association of School Administrators, Arlington, Va.; Quest National Center, Columbus, OH.

1985

33p.

Report No.: ISBN-0-87652-105-7

Available from: Publication Sales, American Association of School Administrators, 1801 North Moore Street, Arlington, VA 22209 (Stock No. 021-00154; specify English or Spanish version; $1.50 plus $2.50 shipping and handling; quantity discounts; orders under $20.00 must be prepaid).

EDRS Price - MF01/PC02 Plus Postage.

The United States has the highest rate of youthful drug abuse of any industrialized country in the world. There is a growing awareness that drug and alcohol use are closely connected to other problems such as teenage suicide, adolescent pregnancy, traffic fatalities, juvenile delinquency, poor school performance, runaways, and dropouts. Youthful drug abuse is a complex and multifaceted problem that cannot be resolved through simplistic or punitive methods. More drug abuse prevention programs are focusing on an approach called "positive prevention" that follows three key principles: (1) helping young people develop skills (e.g., problem solving, critical thinking, effective communication); (2) encouraging youth to adopt a drug free lifestyle; and (3) the development of a peer group that promotes and practices drug-free living. Parents and adults are important role models and function as examples for young people to emulate. They should arm themselves with basic facts about drug use and work to develop and support community-based prevention programs. The document, available in either English or Spanish, includes a list of 10 tips for parents to practice in their homes. (MD)

ED284142 CG020075

Intervention Strategies with Adolescents: The Newton Model.

Green, Matt

May 1987

17p.; Paper presented at the Annual National Symposium on Building Family Strengths (10th, Lincoln, NE, May 13-15, 1987).

EDRS Price - MF01/PC01 Plus Postage.

The problem of adolescent drug/alcohol abuse seems to have once again intensified during the 1980s. When the school is the only constant in an adolescent's life and when those same teenagers bring drugs and alcohol-related problems to school, the school has an obligation to implement change. The first step is identification of the problem. Beyond this, support and train-

ing involves understanding the concept that we are all powerless to solve the problem. Intervention follows, meaning program implementation within the school that educates, evaluates, and confronts students and student athletes about their drug/alcohol problem. The Newton (Massachusetts) Youth Drug/Alcohol program involves these components in fighting adolescent drug and alcohol abuse: (1) evaluation of adolescents with behavioral problems related to drug and alcohol abuse; (2) referrals by athletic personnel, guidance personnel, school psychologists, administrators, local police, court system, and the city human service department; (3) counseling/education/support services reintegrating from residential treatment facilities; (4) group support services for parents; and (5) staff training in the identification of potential problems in adolescence. The program coordinates various groups to provide appropriate services for the adolescent with difficulties. Education about substance abuse is needed to change adolescents' attitudes toward drug and alcohol abuse. (Author/ABL)

ED284098 CG020031
Student Drug and Alcohol Abuse. How Schools Can Help Combat Series.
Towers, Richard L.
National Education Association, Washington, D.C.
1987
225p.
Report No.: ISBN-D-8106-3291-8
Available from: National Education Association Professional Library, P.O. Box 509, West Haven, CT 06516 (Cloth, Stock No. 3292-6, $19.95; Paper, Stock No. 3291-8, $10.95).
EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.
This book was written to help school personnel combat drug and alcohol abuse among students. It gives readers a basic understanding of drugs and their effects on the mind and body. The stages of chemical dependency and the vocabulary of the drug scene are reviewed and reasons that children and adolescents take drugs are discussed. Signs of student drug use are presented. The interrelationships of drug use, behavior problems, eating disorders, chronic truancy, teenage pregnancy, running away, and delinquency are noted. The book emphasizes the importance of schools' working with parents, students, government, and business to combat student alcohol and drug abuse. The major part of the book focuses on methods of preventing student drug and alcohol abuse and what to do when abuse occurs. It includes descriptions of activities, materials, and programs that schools nationwide have found useful. The book also presents an overview of treatment programs and reviews the school's role in aftercare and reentry to school for recovering drug abusers. Relevant information is appended, including lists of State Drug Abuse Prevention Agencies and other organizations to contact for help. References are given and a bibliography of both professional and student resources is included. (NB)

ED283093 CG019982
Guidelines for Competence and Skills Development for Substance Abuse Prevention.
Silverman, Wade H.
Mar 1987
17p.; Paper presented at the Annual Meeting of the Southeastern Psychological Association (33rd, Atlanta, GA, March 25-28, 1987).
EDRS Price - MF01/PC01 Plus Postage.
Substance abuse among adolescents is modeled and reinforced by the peer culture. Experimentation with drugs seems to have become a typical part of normal adolescent development. The solution to adolescent substance abuse will only be arrived at through gathering facts

and designing intervention programs based on those facts. Since the two most widely used drugs are alcohol and marijuana, any intervention must at least focus on these two substances. Interventions should consider the drug, the user, and the setting and should target adolescents, peers, parents, and community leaders. Interventions must provide youth with acceptable, less self-destructive alternatives to substance abuse. Some of these alternatives include competency building, social skills enhancement, assertiveness training, drug-free activities, and anxiety management. Successful programs change both the individual and the environment. While the obvious site for intervention is at the school and most prevention programs have occurred in schools, community-wide programs are another possibility. Community interventions include the use of the media, newsletters, the dissemination of self-help manuals, grassroots organizational development, and lobbying. Great strides have been made in substance abuse prevention in the last decade. (NB)

ED282327 EA019422
Health Related Legal Issues in Education.
Thomas, Stephen B.
National Organization on Legal Problems of Education, Topeka, Kans.
1987
83p.; handling, prepaid; postage and handling will be added on billed
Available from: Publication Sales, National Organization on Legal Problems of Education, 3601 S.W. 29th, Suite 223, Topeka, KS 66614 ($14.50 plus $1.50 postage and handling, prepaid; actual cost of postage and handling will be added on billed orders).
EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.
This monograph analyzes health and safety issues in education in terms of relevant constitutional and statutory provisions. Chapter 1, an introduction, summarizes Fourteenth Amendment equal protection and due process clauses and defines "handicapped" under the Rehabilitation Act. State assistance and student eligibility under the Education for All Handicapped Children Act (EHA) are explained. Chapter 2 presents a history of vaccines for contagious diseases, in a discussion of immunity, liability, and the state's role. Contagious diseases without vaccines are analyzed in chapter 3, which describes disease symptoms and adverse admissions and employment decisions. Diseases cited include Acquired Immune Deficiency Syndrome (AIDS), Crohn's disease, Hepatitis A and B, chicken pox, mononucleosis, etc. The EHA requires supportive services for handicapped children. Chapter 4 discusses case laws and EHA related services, including psychotherapy, nursing care, and climate control. Constitutional implications of drug testing are investigated in chapter 5, which reviews search standards and constitutional and statutory standards affecting school employees and students. Chapter 6 examines historical responses to child abuse and legal requirements concerning educators, as well as reporting mandates and immunity and liability. Chapter 7 discusses student pregnancy in terms of constitutional case laws (exclusion from school and from extracurricular activities, assignment to night programs, and sex education). A table of cases is appended. (CJH)

ED282159 CG019927
REACH Program.
Johnson, Teresa M.; And Others
Mar 1987
9p.; Paper presented at the Annual Meeting of the Northwest Regional Educational Laboratory (1st, Portland, OR, March 4-5, 1987). Printed on colored paper.
EDRS Price - MF01/PC01 Plus Postage.

This document describes the REACH Program, an alternative school program for students who have been suspended for drug or alcohol related offenses, which includes a short-term (7-day) suspension program designed to provide education and assessment and a long-term suspension program which provides 3 to 4 hours of counseling and education per day for 45 days or the remainder of the semester, whichever is greater. Counseling goals listed include: (1) providing parents with education about adolescent substance abuse and strategies to deal with it; (2) educating students about drugs and alcohol and helping them explore their attitudes and substance use; (3) teaching skills to help students to deal with peer pressure and avoid trouble; and (4) recommending community resources and promoting healthy alternatives. Three treatment phases discussed include a denial phase, a phase in which the student accepts that substance abuse has created problems in his or her life, and a phase in which the student commits to abstinence. School work requirements for the programs are discussed and relevant sections of the school code are included. (NB)

ED282129 CG019894
Project SMART: A Social Approach to Drug Abuse Prevention. Teacher's Guide.
Johnson, C. Anderson; And Others
University of Southern California, Los Angeles. Inst. for Health Promotion and Disease Prevention Research.
1986
169p.
EDRS Price - MF01/PC07 Plus Postage.
This document presents the teacher's guide for an experimental research and demonstration project which focuses on the prevention of drug abuse among youth through self-management and resistance training. The major purpose of the curriculum described in this document is to prevent and reduce the incidence of habitual cigarette smoking and of alcohol and marijuana abuse among students in grades six through nine. An introduction and an explanation of the project's theoretical sources are followed by a description of the operationalization of Project SMART (Self-Management and Resistance Training). Project SMART activities, peer skill leaders, role playing, peer skill leader training, and ideas on how to answer questions about drugs are discussed. Fact sheets on drugs are included. The second part of the document contains the 12 program sessions of the Project SMART curriculum. Sessions A and B concern choosing students to be skill leaders and skill leader training. Curriculum sessions 1 through 10 are: (1) Welcome to SMART; (2) Consequences; (3) Prevention Baseball; (4) Techniques to Say "No"; (5) Peer Pressure Resistance; (6) Normative Expectations; (7) How Advertising Influences Us; (8) Developing Anti-Drug Commercials; (9) Adult Influences; and (10) Standing Up For Myself. For each session, the main objective is stated and a list of necessary materials is provided. Individual activities within each session are described along with the time needed to complete the activity and the presentation method used. Worksheets used in the curriculum are included. (NB)

ED281955 UD025512
CRACKDOWN: A Guide to Preventing Substance Abuse Secondary. Citywide Teach-in--September 30.
New York City Board of Education, Brooklyn, N.Y. Div. of Curriculum and Instruction.
1986
49p.; For elementary level guide, see UD 025 511.
Report No.: ISBN-88315-814-0

Available from: New York City Board of Education, Curriculum Editorial and Production Unit. Office of Curriculum Development and Support, Room 613, 131 Livingston St., Brooklyn, NY 11201 ($3.00).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

This secondary school curriculum guide, the subject of a citywide teach-in in the New York City schools, provides facts, lessons, and learning activities designed to provide information about and to prevent the use of crack, a form of cocaine. The guide covers the facts about crack, the reasons given for using crack, strategies for saying no to drugs, and insight into making decisions on drug use. These core materials are supplemented by lessons in the subject areas of social studies, science, mathematics, and communication arts. The subject area lessons provide information of the dangers of crack to the individual, to the community, and to the country. Follow-up activities are also suggested. This material is divided into nine lessons: (1) Crack A National Epidemic; (2) Crack: It's Your Decision; (3) Pharmacology of Crack; (4) How Medicines or Drugs Can Affect Our Bodies; (5) Drug Use and Body Chemistry; (6) A Tale of Human Bondage: Interview with a Crack Dealer; (7) Effects of Crack on Our Society; (8) The High Cost of Crack; and (9) Who Is Responsible for Halting the Crack Epidemic? A fact sheet for teachers and a poster are included. (KH)

ED281954 UD025511

CRACKDOWN: A Guide to Preventing Substance Abuse Elementary. Citywide Teach-in--September 30.

New York City Board of Education, Brooklyn, N.Y. Div. of Curriculum and Instruction.

1986

41p.; For secondary level guide, see UD 025 512.

Report No.: ISBN-88315-813-2

Available from: New York City Board of Education, Curriculum Editorial and Production Unit, Office of Curriculum Development and Support, Room 613, 131 Livingston St., Brooklyn, NY 11201 ($3.00).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

This elementary school curriculum guide, the subject of a citywide teach-in in the New York City schools, provides facts, lessons, and learning activities designed to provide information about and to prevent the use of crack, a form of cocaine. The lessons are divided into two groups, one for grades K-3 and the other grades 4-6. The primary curriculum consists of four interdisciplinary lessons: (1) You Are What You Eat: How Foods Help Us; (2) Dangers in the House; (3) Dangers in Your Medicine Cabinet; and (4) Pinocchio Goes to Pleasure Island: A Story of Peer Pressure. These lessons provide a framework for teaching about substance abuse if the children raise this problem. The lessons for grades 4-6 focus on the facts about crack, the reasons people give for using crack, how to say no, and on deciding whether to use drugs: titles of lessons are (1) Pharmacology of Crack: What It Does to the Body; (2) Reasons Given for Drug Abuse; and (3) Consequences of Using Crack. Follow-up activities for grades 4-6, a fact sheet for teachers, a poster, and an evaluation form are also included. (KH)

ED281304 EA019368

Drug and Alcohol Abuse in the Schools: A Practical Policy Guide for Administrators and Teachers on How to Combat Drugs and Alcohol.

Lewis, John F.; And Others

National Organization on Legal Problems of Education, Topeka, Kans.

1987

44p.

Available from: Publication Sales, National Organization on Legal Problems of Education, Southwest Plaza Building, 3601 S.W. 29th Street, Suite 223, Topeka, KS 66614 ($9.95 plus $1.50 postage and handling, prepaid; actual postage and handling will be added on billed orders).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

This manual focuses on legal issues confronting schools in the area of substance abuse and provides practical policy guidance to public school managers in enforcing a substance abuse policy. After a brief introduction, section 2 examines barriers to action, commenting on several myths affecting drug abuse policy. Section 3 deals with substance abuse by school employees, addressing these topics: (1) establishing substance abuse policies; (2) testing employees for drug or alcohol use, commenting on types of testing and matters of privacy; (3) disciplining employees for the use of, impairment from, or possession of drugs or alcohol and citing pertinent laws and the Federal Rehabilitation Act; and (4) assisting employees with substance abuse problems. Section 4, on substance abuse by students, addresses these topics: (1) establishing a substance abuse policy for students; (2) prohibitions; (3) methods and procedures of enforcement, commenting on reasonable suspicion and reasonable scope of search; (4) due process requirements; (5) discipline; (6) voluntary drug testing; (7) mandatory testing of student athletes; and (8) the need for a reasoned and personalized approach. A drug and alcohol abuse policy checklist; 13 appendices containing sample policies, notices, and forms; and a glossary conclude the manual. (WTH)

ED281267 EA019253

EAP: Employee Assistance Programs in the Public Schools. Reference & Resource Series.

Hacker, Carol

National Education Association, Washington, D.C.

1986

50p.

Report No.: ISBN-0-8106-1533-9

Available from: Publication Sales, NEA Professional Library, P.O. Box 509, West Haven, CT 06516 (Stock No. 1533-9-00; $6.95).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

Employee assistance programs (EAP's) have been set up by many businesses and organizations to help employees resolve their personal problems so they can maintain or resume an acceptable job performance level. So far, only a few public school districts have considered or implemented such programs. This monograph examines EAP's in general and focuses on their feasibility for school districts. While communities willingly support specialized services for students needing help with academic choices and personal problems, school district employees' problems have not been addressed because of scarce financial resources and schools' concern about public image. Yet keeping adult workers highly productive seems as worthy a goal as turning students into good workers. Chapter 2 considers three alternative models for school EAP's, while chapter 3 discusses available services, staff, referrals, and publicity methods. Chapter 4 tackles a variety of issues, including client population, wellness programs, organizational fit, recordkeeping, and legal problems. Chapter 5 treats measurement of EAP effectiveness, focusing on absenteeism and job performance evaluations as the best indicators. The last chapter outlines seven steps for developing and implementing a school district EAP. An appendix with forms and guidelines, a bibliography of 20 references, and a list of EAP organizations and publications are included. (MLH)

ED281095 CG019829

Separating Effects of Frequency, Quantity, Disruptive, and Problematic Substance Use.

Stein, Judith A.; And Others

Apr 1987

8p.; Paper presented at the Annual Meeting of the Western Psychological Association (67th, Long Beach, CA, April 23-26, 1987).

Sponsoring Agency: National Inst. on Drug Abuse (DHHS/PHS), Rockville, Md.

EDRS Price - MF01/PC01 Plus Postage.

There is widespread concern about the use and abuse of alcohol and other drugs by adolescents and young adults. It has yet to be determined whether drug use in itself is invariably associated with disruptive or problem use of drugs. Additionally, drug use may vary by frequency and quantity of ingestion which may be differentially related to disruptive or problem use of drugs. To explore these issues, data were obtained from 739 young adults as part of an 8-year longitudinal study of drug use and abuse. A multitrait/multimethod approach with latent variable models was used to separate use factors of particular drugs (alcohol, cannabis, hard drugs, cocaine) from latent constructs of general drug use frequency, quantity, disruptive drug use, and problem drug use. Self-reported frequency of use measures were based on 7-point rating scales that ranged from "no use" to "more than once a day." Twenty-one different substances were assessed; there were two quantity of drug use measures. Disruptive and problem drug use were also assessed. Regression paths between Drug Use Frequency and Disruptive and Subjective Problem Drug Use were not significant; however, the paths between Drug Use Quantity and Subjective Problem Use were significant at greater than the .01 level. These results tend to suggest that the quantity of substances used is more important in the etiology of problem and disruptive use of drugs than is frequency of use for young adults. (NB)

ED281092 CG019826

What College Students Are Telling Us about Alcohol Abuse Prevention.

Griffith, Jeanne A.; Kile, Marilyn J.

Sep 1986

8p.; Paper presented at the Annual Meeting of the American Public Health Association (114th, Las Vegas, NV, September 28-October 2, 1986).

EDRS Price - MF01/PC01 Plus Postage.

This paper describes the successful use of student focus groups by the University of Wisconsin--Whitewater Student Health Center to assess marketing strategies for alcohol abuse prevention. The focus group is a group of 13 students who met several times with a facilitator to share perceptions, feelings, and attitudes about alcohol abuse prevention. It is noted that group members reviewed pamphlets, posters, advertisements, slogans, films, and videos. Examples are included of which verbal, written, and visual approaches were most appealing to them. Four ideas for alcohol abuse prevention recommended by the focus group as being potentially effective with college students are presented: (1) using graphic portrayals of the results of a drunk driving accident; (2) emphasizing the importance of protecting a friend; (3) advertising the costs of alcohol abuse; and (4) showing how to have fun without alcohol or that drinking moderately was acceptable. It is concluded that the use of focus groups demonstrates to students the importance of their opinions, that the focus group is a proven marketing tool, and that focus groups provide an easy and inexpensive way to gather important information on the feelings and attitudes of college students. (Author/NB)

ED280145 EA019250

Drug Testing in Schools: Implications for Policy.

Bozeman, William C.; And Others

National School Boards Association, Alexandria, VA. Educational Policies Service.

Updating School Board Policies, v18 n3 p1-3 Mar 1987 Mar 1987

5p.

EDRS Price - MF01/PC01 Plus Postage.

Public concern about substance abuse, fueled by political and media attention, is causing school administrators to consider a variety of approaches beyond traditional drug education. No procedures, methods, or rules regarding drug testing should be established in the absence of clear school board policy, and no policy decisions should be made before the ethical, legal, practical, and financial issues are carefully considered. Among the legal considerations are the constitutional rights of students and employees, particularly the right to freedom from unreasonable search and seizure and to due process and equal protection of the law. Practical issues include the significant number of safeguards required to ensure the accuracy and reliability of drug testing and related record keeping. Although there are several kinds of tests available, the most commonly preferred method is also the most expensive and complex. None of the available tests serves as more than an indicator of possible substance abuse, and no single test covers all possible situations, conditions, or materials. When considering adoption of drug screening policy, school board members should consider whether the procedures will protect personal rights, what use will be made of test results, and whether the resulting benefit is worth the costs and the risk of litigation. (PGD)

ED279644 SP028641

Drug Abuse: Prevention Strategies for Schools. ERIC Digest 17.

Barrett, Joan

ERIC Clearinghouse on Teacher Education, Washington, D.C.

1986

4p.

Sponsoring Agency: Office of Educational Research and Improvement (ED), Washington, DC.

Contract No.: 400-83-0022

EDRS Price - MF01/PC01 Plus Postage.

Efforts to fight drug abuse must occur in the schools, as well as in homes and the community, since schools provide one major influence in transmitting values, standards, and information to children. This digest discusses the extent of drug abuse among youth, why drug abuse occurs, the effects of drug abuse, what schools can do to combat the problem, some promising prevention programs, what teachers and principals can do, and future needs. (JD)

ED279285 HE020135

Collegiate Alcohol Risk Assessment Guide.

Anderson, David S.; Janosik, Steven M.

Campus Alcohol Consultations, Washington, DC.

1986

9p.; For related documents, see HE 020 130 and HE 020 134-136.

Available from: Campus Alcohol Consultations, P.O. Box 65557, Washington, DC 20035 ($3.50 per copy; $3.00 per copy for 10 or more; $2.50 per copy for 50 or more; $2.00 per copy for 100 or more).

EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.

An instrument to help administrators assess the liability resulting from alcohol-related activities on the college campus is presented. The hazards and associated liability of these events can be reduced by developing an aggressive risk management strategy designed to inform, educate, and coordinate the actions of individuals and groups associated with these activities. An affirmative response to a question on this checklist indicates that a preventive risk management measure exists, while a negative rsponse identifies an area for further attention and possible development. The 103 questions concern: alcohol policy, advertising, general procedures, parties and social events, staff training, faculty/staff advisers, approval agents, sellers of alcohol, servers of alcohol, prevention and alcohol education, social hosts, program identification and treatment, and research. (SW)

ED279284 HE020134
Alcohol Risk Management Survey Summary.
Janosik, Steven M.; Anderson, David S.
Campus Alcohol Consultations, Washington, DC.
1986
7p.; For related documents, see HE 020 130 and HE 020 135-136.
Available from: Campus Alcohol Consultations, P.O. Box 65557, Washington, DC 20035.
EDRS Price - MF01/PC01 Plus Postage.
Results of the Alcohol Risk Management Survey, which was completed by 325 college chief student affairs officers at four-year institutions, are presented. Adapted from the "Collegiate Alcohol Risk Assessment Guide," the survey assesses the management of alcohol-related activities on the college campus, with a focus on policy, procedure, intervention, and education. Among the trends are: private and public institutions have developed approprate alcohol policies; policies and procedures differed significantly by institutional type; intervention strategies and educational programs to help manage the risk associated with alcohol on the college campus have not been developed to the same extent as general policy; a high percentage of respondents indicated that a number of important educational opportunities designed to reduce risk never occur on their campuses; group events where alcohol is served declined over the past several years; and knowledge of state and local laws and risks associated with the use of alcohol among students is rising. In addition to a brief narrative summary, the survey questions and responses are provided. A four-point Likert scale was used to score responses to each item. (SW)

ED278925 CG019704
10 Steps to Help Your Pre-Teen Say "No."
National Clearinghouse for Alcohol Information (DHHS), Rockville, Md.; National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.
1986
29p.; For related document, see CG 019 703.
Report No.: DHHS-ADM-86-1418
Available from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.
EDRS Price - MF01/PC02 Plus Postage.
Government: Federal
This booklet is one of two publications designed to assist parents in guiding their preadolescents away from experimentation with alcohol, tobacco, and other drugs, while enhancing the parent-child relationship. The book is divided into 10 steps: (1) talk with your child about alcohol; (2) learn to really listen to your child; (3) help your child feel good about himself or herself;

(4) help your child develop strong values; (5) be a good model or example; (6) help your preteen deal with peer pressure; (7) make family policies that help your child say "no;" (8) encourage healthy, creative activities; (9) team up with other parents; and (10) know what to do if you suspect a problem. A conclusion and review section lists, in outline form, the 10 steps to help preadolescents say "no" to alcohol and other drugs, and key points of each step. Resource groups that can provide additional information to parents are listed and references are included. A special note to group leaders is provided for readers intending to use this publication in workshops to enhance parenting and general communication skills. (NB)

ED278924 CG019703
Helping Your Pre-Teen Say "No": A Parent's Aid.
National Clearinghouse for Alcohol Information (DHHS), Rockville, Md.; National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.
1986
17p.; For related document, see CG 019 704.
Report No.: DHHS-ADM-86-1417
Available from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.
EDRS Price - MF01/PC01 Plus Postage.
Government: Federal
This brochure is one of two publications designed to assist parents in guiding their preadolescents away from experimentation with alcohol, tobacco, and other drugs, while enhancing the parent-child relationship. It contains a broad overview of prevention. The book is divided into 10 sections. Each section provides suggestions and answers to a question about substance abuse prevention for preadolescents. The 10 questions discussed in the book concern: (1) learning what to say to a child about alcohol; (2) encouraging children to turn to their parents for guidance; (3) enhancing the child's self-esteem and helping him say "no" to alcohol and other drugs; (4) teaching values at home to help children resist peer pressure to use alcohol; (5) serving as a role model; (6) using peer pressure skills; (7) making family policies concerning alcohol experimentation; (8) preventing alcohol experimentation; (9) joining with other parents to fight preadolescent drug experimentation; and (10) being prepared to help children who, in spite of parental efforts, may drink anyway. Signs of alcohol abuse are listed and sources of help are suggested. (NB)

ED278917 CG019696
Through My Child's Eyes.
Streit, Fred
Peoplescience, Inc., Highland Park, NJ.
[1987
20p.
EDRS Price - MF01/PC01 Plus Postage.
This pamphlet provides an overview to help parents understand the roots of teenage drug abuse, alcohol abuse, and crime, and describes ways of enhancing the family and moving to prevent substance abuse through support packages. A section on measuring perceptions identifies eight clusters of behavior which cover the circle of what children perceive (love, loving control, control, hostile control, hostility, hostile freedom, freedom, loving freedom). Research is cited which revealed that perceptions of loving freedom, love, and loving control were associated with no substance abuse. Actions, motivation, timing, choice, and benefits are presented as five elements

that impact on the child's perception of love. Parental standards and expectations, and what children must do to meet them, are discussed. Guidelines are given for effective parent-child communication. A final section considers how parents can infuse their standards and values in their children. The pamphlet concludes with descriptions of five kits designed to equip parents with the necessary tools to develop an understanding of adolescent substance abuse and to take steps to prevent substance abuse in their own children. Use of the kits with children in three age groups (4-9 years, 10-12 years, and 13-18 years) is explained. The five kits closely follow the philosophy of the document and include: (1) Perceptions; (2) Expectations and Standards; (3) The Perception of Loving and Being Loved; (4) Communications-Matching Wavelengths; and (5) Imparting Standards and Values. (NB)

ED278912 CG019691

Alcohol: The Gateway Drug. Alcohol Supplement to the Drug Education Curriculum.

New York State Div. of Alcoholism and Alcohol Abuse, Albany.; New York State Education Dept., Albany. Bureau of Curriculum Development.

1986

74p.; For Drug Education Curriculum, see ED 276 952-953.

EDRS Price - MF01/PC03 Plus Postage.

Government: State

This document presents an alcohol supplement to New York's Drug Education Curriculum. The supplement is designed to address the unique circumstances that distinguish educational strategies about alcohol from those applied to other drugs. Section I, Introduction, describes the strategy suggested by this document as being based on health promotion, risk reduction, and prevention and management of health problems. The central goal of this supplement is to discourage any alcohol use by children. Section II, New Messages about Alcohol, contains the basic philosophy and messages that comprise a comprehensive approach to alcohol education. The 15 messages in this section are categorized in four broad subject areas: (1) the drug alcohol; (2) alcohol use; (3) alcohol problems; and (4) influences on alcohol use. Section III, Classroom Activity Guide, and the bibliography, References and Resources (Appendix C), are also organized by these four areas to facilitate cross-referencing of messages with related activities and sources of information. Classroom activities are further divided by grade: primary, intermediate, and junior and senior high school. Section IV, Program and Policy Guide, includes examinations of school-based, community-based, and combined efforts to deal with driving while intoxicated prevention; identification and treatment of chemically dependent young people; parent education; and community organization. Appendices contain the National PTA resolution on alcohol and drug use by minors; definition, goals, and objectives of a local council on alcoholism and a list of local councils; and references and resources. An evaluation form is included. (NB)

ED278880 CG019658

Desk Reference Manual on Student Drug and Alcohol Use: A Comprehensive Planning Guide.

Grauf-Grounds, Claudia

New Jersey State Dept. of Education, Trenton. Div. of General Academic Education.

1985

140p.

EDRS Price - MF01/PC06 Plus Postage.

Government: State

This planning guide was created to help educators plan and implement projects to reduce student abuse of drugs and alcohol. Chapter 1, Perspectives, briefly describes four commonly held perspectives regarding substance abuse: (1) moral-legal; (2) public health; (3) psychosocial; and sociocultural. A brief history of the ways in which New Jersey schools have addressed substance abuse is also presented. Chapter 2, Planning, emphasizes the importance of a thorough planning process and includes methods for problem definition and needs assessment. Chapter 3, Curricula and Programs, describes types of curricula and programs that can be used in reducing student substance abuse. Prevention, intervention, and treatment services are included. The use of community agencies, staffing, and funding are addressed. Chapter 4, Policies and Procedures, presents a process and model for constructing a source substance abuse prevention policy and discusses common legal and policy issues that arise in the development of comprehensive substance abuse projects. Chapter 5, Evaluation, discusses process, outcome, and impact evaluation and suggests strategies for thorough and useful evaluation of substance abuse projects. The appendices offer listings of additional resources, including model programs, training resources, bibliographies, information sources, state and county agencies, and self-help groups. (NB)

ED278109 EA019106

Schools against Drugs: The Impact Program at Newberg School District.

Leatt, Desmond J.

Oregon School Study Council, Eugene.

OSSC Bulletin, v30 n5 Jan 1987 Jan 1987

36p.

Available from: Publication Sales, Oregon School Study Council, University of Oregon, 1787 Agate Street, Eugene, OR 97403 ($4.00 prepaid; $1.50 shipping and handling will be added on billed orders).

EDRS Price - MF01/PC02 Plus Postage.

In 1984 the Newberg (Oregon) School District began its Impact Program for limiting substance abuse. The program's primary purposes are to raise awareness, disseminate information, intervene when chemicals seem to be hampering success in school, refer users to treatment centers, and provide support for those returning after treatment. This report's first chapter describes the program's origin in training provided by a Portland (Oregon) hospital. Based on the premise that addiction is a treatable disease that follows a predictable pattern, the training was first offered to teachers, counselors, administrators, board members, police liaison officers, parents, and church leaders. These trainees then provided workshops and inservice programs for others. Once trained, the team members intervene in the lives of students suspected of drug abuse. Chapter 2 describes how substance abusers are identified, referred for treatment, treated, and returned to school. The third chapter describes the objectives of the Impact Program's substance abuse prevention component and its place in the district curriculum. The fourth chapter explains community involvement in the program. Appendices provide the student referral form used, a scope and sequence chart for substance abuse prevention curricula from kindergarten through the fifth grade, and a 1986 flyer describing the program. (PGD)

ED276936 CG019553

The Drug Free School: What School Executives Can Do. Education USA Executive Summary #1.

McCurdy, Jack, Ed.; And Others

National School Public Relations Association, Arlington, Va.

1986

17p.
Available from: National School Public Relations Association, 1501 Lee Highway, Suite 201, Arlington, VA 22209.
EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.
This document presents an executive summary concerned with drug use in the schools. The introduction outlines the dimensions of the problem and the prevalence of drug use among adolescents. A section entitled "What Works" reports on the state-of-the-art drug prevention program which involves the social influence/resistance skills technique. Four key elements of this approach are described: (1) correction of misperceptions; (2) peer resistance skills; (3) family influences; and (4) media influences. New and old drug prevention programs are discussed; when, where, and how to use drug prevention programs are considered; intervention programs are described; and a comprehensive effort is recommended. A section on reviewing and evaluating drug programs discusses characteristics of a good drug policy, how to develop a drug policy, needs assessment, program evaluation, and legal issues in drug programs. The final section examines how to effectively communicate an anti-drug program. It provides information on getting organized, publicizing school board policy and procedures, developing a public relations plan, forming an action committee, cooperating with other agencies, educating the school staff about their role, fighting rumors, cooperating with reporters, and evaluating efforts. Information is provided for obtaining additional resources in drug prevention. (NB)

ED276691 SP028216
"Not for Me " An Educ-Coloring Book and Teacher's Guide.
Chernow, Fred; Chernow, Carol
1986
51p.
Report No.: ISBN-0-9610742-1-3
Available from: Purcell Productions, Inc. 484 West 43 St. (23 M), New York, NY 10036 (Family Pack (4 + Guide) $17.95).
EDRS Price - MF01 Plus Postage. PC Not Available from EDRS.
"Not for Me " presents a novel approach to drug abuse prevention. The time-tested vehicle of the coloring book is used along with a carefully-worded caption on each of its thirty-one pages. Both the caption and naturalistic art work are geared to saying "No " to drugs. The detailed Teacher's Guide provides the classroom teacher or concerned parent with a complete Lesson Plan for each page in the Edu-Coloring Book. The classroom-tested Guide provides the teacher with a comprehensive outline to accompany each page of the book. These learning aids are: Aim of the Lesson, Vocabulary, Materials, Motivation, Picture Study, Teacher Questions, Follow-up Activities, and Related Reading. Other features of the Guide include methods of correlating traditional school subjects to drug prevention. References are made to Science, Social Studies, Math, Hygiene, and Writing Skills. Related readings are listed for each page to expand both the teacher's and pupil's knowledge. A list of current audio-visual materials is included to help teachers further vitalize the topics covered. Complete step-by-step directions to the teacher are included. Cover materials provide the reader with free and inexpensive teaching material sources, toll-free 800 telephone numbers for direct help, and a ten-step Parent's Guide on how to help their child say "No" to drugs. (Author)

ED275929 CG019461
Communicating with Youth about Alcohol: Methods, Messages, & Materials.
National Clearinghouse for Alcohol Information (DHHS), Rockville, Md.

1986
36p.
Sponsoring Agency: National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.
Report No.: DHHS-ADM-86-1429
EDRS Price - MF01/PC02 Plus Postage.
Government: Federal

This publication is intended to provide direction to volunteers and professionals working to reduce teenage alcohol abuse through public education efforts. It includes the most recent research on the alcohol-related knowledge, attitudes, and practices of youth. It also provides information on motivating adolescents to avoid alcohol or, if they have experimented, to stop or avoid regular use. The guide offers ways to plan and develop messages and materials about alcohol so that adolescents will respond favorably. Chapter 1 presents current research findings on adolescent alcohol use, attitudes, and knowledge and discusses reasons why adolescents use alcohol and the risks associated with its use. In chapter 2, communication strategies that have proved effective in educating and motivating youth to avoid alcohol and other drugs are described. Included are recommendations on selecting target groups, media, and message content. Chapter 3 outlines a six-step process for planning, developing, promoting, and distributing messages and materials for youth about alcohol: (1) planning and strategy development; (2) concept development; (3) message execution; (4) promotion and distribution; (5) evaluation; and (6) feedback. Appendices contain peer resistance strategies for saying no, a list of resource groups, and a 40-item bibliography. (NB)

ED274933 CG019437
For Coaches Only: How to Start a Drug Prevention Program.
Drug Enforcement Administration (Dept. of Justice), Washington, D.C.
[1986
17p.; For related document, see CG 019 438.
EDRS Price - MF01/PC01 Plus Postage.
Government: Federal

This booklet encourages school athletic coaches to develop drug prevention programs in their schools. The following topics are discussed: (1) reasons for coaches to be involved in drug prevention programs; (2) awareness of alcohol and drug abuse as a hidden problem in athletes; (3) statistics on drug and alcohol abuse in high school students and athletes; and (4) the harmful effects of drugs and alcohol on physical activities and mental abilities. A list of drug/alcohol abuse prevention program activities in which coaches can be involved is provided. These suggestions include opening a dialogue with athletes on alcohol and drug abuse, knowing the symptoms of alcohol and drug abuse, and enforcing all training rules. Relevant quotations of athletic program administrators are contained throughout the document. Resources which can provide additional information are listed, including a specific packet of material available from the Drug Enforcement Administration. (ABL)

ED273239 HE019655
Drug Use among American High School Students, College Students, and Other Young Adults. National Trends Through 1985.
Johnston, Lloyd D.; And Others
Michigan Univ., Ann Arbor. Inst. for Social Research.
1986
247p.; Some tables contain small print.

Sponsoring Agency: National Inst. on Drug Abuse (DHHS/PHS), Rockville, Md.
Grant No.: 3-RO1-DA-01411
Report No.: DHHS-ADM-86-1450
Available from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC, 20402.
EDRS Price - MF01/PC10 Plus Postage.
Government: Federal

Drug use and related attitudes of U.S. high school seniors from the graduating classes of 1975-1985 and young adults in their late teens and early- to mid-twenties were studied, as part of an ongoing research project. Eleven classes of drugs were assessed: marijuana (including hashish), inhalants, hallucinogens, cocaine, heroin, other natural and synthetic opiates, stimulants (amphetamines), sedatives, tranquilizers, alcohol, and cigarettes. Several subclasses of drugs were also covered: PCP and lysergic acid diethylamide (LSD), amyl and butyl nitrites, and barbiturates and methaqualone. Attention was focused on drug use at the higher frequency levels rather than whether respondents had ever used various drugs. Of concern were: age of first use; the seniors' own attitudes and beliefs; and the attitudes, beliefs, and behaviors of others in the seniors' social environment, including perceived drug availability. The use of non-prescription stimulants, including diet pills, stay-awake pills, and pseudo-amphetamines were also reported, along with cocaine use among young people. Findings include sex differences in drug use, differences related to college plans, regional differences, and differences related to population density. The implications of findings for prevention efforts were addressed. (SW)

ED272830 CG019314

Local Education Authority Policies and Practices Relating to Drugs Education and Drug Misuse: Report of a Questionnaire and Interview Survey of LEAs in England and Wales.

Hodgson, Ann; Streatfield, David
Sep 1985
10p.
EDRS Price - MF01/PC01 Plus Postage.

In order to identify and document Local Education Authority (LEA) policies and practices in relation to drug misuse and drugs education, a questionnaire was designed which examined: (1) LEA policy development and adoption; (2) staff with designated responsibility to coordinate and implement policies; (3) working parties and subcommittees; (4) staff working in schools and colleges; (5) curricular materials used in schools; (6) in-service training; and (7) the role of youth and community workers. The questionnaire was completed by 87 LEAs in England and Wales. The result revealed that only five percent of responding LEAs reported having done nothing under all seven headings. The majority of LEAs reported being involved in four or more of the seven activities. Metropolitan authorities consistently reported more activity than county authorities or London boroughs throughout the survey. Most LEAs reported having addressed the problem of hard drugs misuse within a broad health and social education context and having treated this as a community, rather than simply as a school problem. The report concludes that it would be useful to examine the effect of this sort of approach in relation to the more frequently occurring forms of drug misuse in schools, including illicit or excessive drinking. (NB)

ED272805 CG019288

A Guide to Planning Alcoholism Treatment Programs.

McGough, Dixie P.; Hindman, Margaret H.
Informatics, Inc., Rockville, Md.

1986
98p.
Sponsoring Agency: National Inst. on Alcohol Abuse and Alcoholism (DHHS), Rockville, Md.
Contract No.: 84MO57635601D; 84MO57635801D
Report No.: DHHS-ADM-86-1430
Available from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.
EDRS Price - MF01/PC04 Plus Postage.
Government: Federal
This guide contains information from the alcoholism literature and from interviews with people in state alcoholism agencies, major professional associations, and public and private service programs. It is designed to help readers plan and develop community alcoholism programs by providing an overview of the many considerations involved in starting and operating a program and by identifying resources that offer more information. The first part of this report concerns planning the program and includes sections on: (1) an overview of alcoholism treatment; (2) foundations for success in planning; (3) needs assessment; (4) program design considerations; and (5) administrative and management issues. Administrative and management issues discussed include organizational structure, staffing and personnel management, recordkeeping and reporting, program evaluation, quality assurance facilities and location, funding and fund raising, and budgeting and cost accounting. The second part of this report discusses needs assessment, outreach, treatment considerations, and administrative issues for serving the special populations of the elderly, youth, the multidisabled, American Indians, Black Americans, Hispanic Americans, Asian/Pacific Americans, and women. The appendices contain lists of further readings, organizations and information resources, and state and territorial alcoholism program directors. (NB)

ED271666 CG019205
Drug Traffic and Abuse in Schools: NSSC Resource Paper.
National School Safety Center, Sacramento, CA.
Mar 1986
22p.; For overviews on student and staff victimization, and safe schools, see CG 019 206-207.
Sponsoring Agency: Office of Juvenile Justice and Delinquent Prevention (Dept. of Justice), Washington, D.C.
Grant No.: OJJDP-85-MU-CX-0003
EDRS Price - MF01/PC01 Plus Postage.
Government: Federal
Drug abuse in schools, and to a lesser extent, alcohol and tobacco abuse are the topics of this paper. The paper is divided into the following sections: (1) prevalence of drug abuse; (2) student attitudes and beliefs; (3) drug laws and school rules; (4) student searches and drug testing; (5) drug epidemic reaches very young; (6) tobacco abuse; (7) alcohol abuse; (8) marijuana abuse; (9) related problems; (10) the war against drugs; (11) drug abuse prevention strategies; and (12) drug abuse intervention strategies. Within the discussion of these topics are statistics and quotations from experts, researchers, newspapers, journals, agencies, and government officials. A list and description of drug and alcohol abuse prevention programs operating in schools is provided. Lists of relevant drug and alcohol abuse literature, toll-free telephone help lines, and national organizations (with addresses) which can provide assistance with drug and alcohol intervention projects are included. (ABL)

ED271523 UD024968

Use of Licit and Illicit Drugs by America's High School Students, 1975-1984.

Johnston, Lloyd D.; And Others

Michigan Univ., Ann Arbor. Inst. for Social Research.

1985

164p.; Some tables may be marginally legible due to small type.

Sponsoring Agency: National Inst. on Drug Abuse (DHHS/PHS), Rockville, Md.

Grant No.: 3-R01-DA-01411

Report No.: DHHS-ADM-85-1394

Available from: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

EDRS Price - MF01/PC07 Plus Postage.

Government: Federal

Two of the major topics treated in this report are the current prevalence of drug use among American high school seniors, and trends in use since 1975. Also reported are data on school grade of first use, trends in use at earlier grade levels, intensity of drug use, attitudes and beliefs among seniors concerning various types of drug use, and their perceptions of certain relevant aspects of the social environment. The eleven separate classes of drugs distinguished are marijuana (including hashish), inhalants, hallucinogens, cocaine, heroin, natural and synthetic opiates other than heroin, stimulants, sedatives, tranquilizers, alcohol, and cigarettes. Separate statistics are also presented here for several sub-classes of drugs: PCP and LSD, barbiturates and methaqualone, and amyl and butyl nitrites. Occasions of medically supervised use of the psychotherapeutic drugs were excluded. Attention was focused on high frequency levels of drug use and an indirect measure of dosage per occasion was introduced to differentiate levels of drug use. The "Other Findings" section includes data on the use of non-prescription stimulants, daily marijuana use, effects of post high school environments and role transitions on drug use, and the issue of distinguishing maturational change from period effects and class cohort differences. Findings are supported by numerous tables. (Author/MCK)

ED265180 TM860027

Project Connect: 1984-85 Final Technical Report.

Austin Independent School District, Tex. Office of Research and Evaluation.

Jun 1985

45p.

Report No.: AISD-ORE-84-44

Available from: Austin Independent School District, Office of Research and Evaluation, 6100 Guadalupe, Box 79, Austin, TX, 78752. ($1.65 plus $1.00 for postage).

EDRS Price - MF01/PC02 Plus Postage.

Project Connect operates as an intervention/prevention service for students in grades nine through twelve at risk of abusing alcohol and/or drugs in the Austin Independent School District (Texas). On the average, the 278 students in the Project were seen once a week in individual or group sessions lasting from 5 to 45 minutes. Intervention sessions occurred during class and focused on: building self-concept; providing positive alternatives to alcohol/drug use; alcohol/drug education; and personal concerns (such as suicide) and school concerns (such as not liking school and conflicts with teachers). Nearly all students believed Project Connect had helped them in limiting their consumption of alcohol and/or drugs. Connect appeared to have a

positive impact on student grade point averages (GPA's). Students involved in the program the longest had the highest GPA's. An executive summary lists the major positive findings and the major findings requiring action. Included in the appendices of the final report are student records, the student survey and results, and Project Connect contact logs. (PN)

ED255855 CG018187
Adolescent Alcohol Abuse. Fastback Series No. 217.
Horton, Lowell
Phi Delta Kappa Educational Foundation, Bloomington, Ind.
1985
48p.; This fastback was sponsored by the Ohio State University Chapter of Phi Delta Kappa.
Report No.: ISBN-0-87367-217-8
Available from: Phi Delta Kappa, Eighth Street and Union Avenue, Box 789, Bloomington, IN 47402 ($0.75).
EDRS Price - MF01/PC02 Plus Postage.
This booklet examines the problem of alcohol use among American teenagers. The role that alcohol plays in adult society is presented and its potential danger for causing teenage alcohol addiction is considered. A discussion on why some teenagers abuse alcohol focuses on familial, peer, sociocultural, environmental, personality, and behavioral influences. Fourteen specific behaviors and characteristics which may be symptomatic of alcohol or drug abuse in students are identified. The literature and research in the areas of the current legal drinking age controversy, the problem of teenage drinking and driving, and the sometimes lethal result of mixing alcohol and other drugs are reviewed to help educators become better informed about issues impinging directly or indirectly on teenage alcohol use and abuse. Finally, the role of the school in the education, prevention, and treatment of adolescent alcohol use and abuse is considered in view of the many potential individual and societal problems caused by alcohol. (NRB)

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Laurie Lachance, M.A., has worked as a substance abuse counselor, served as an educator for the community in substance abuse awareness programs, and published several articles on alcohol and drug abuse issues. She was one of the creators of a re-entry program for a long-term residential treatment program in Michigan, and served as the program's director for several years. Ms. Lachance has a bachelor of arts degree in psychology and a master of arts degree in rehabilitation counseling from The University of Michigan, and is a Certified Rehabilitation Counselor. She has worked for ERIC/CAPS as a writer and coordinator of computer and information services.